Iowa River Psychiatry and Counseling

Informed Consent Statement

Thank you for choosing Iowa River Psychiatry and Counseling. The following is information about our services and what to expect with evaluation and treatment. All initial appointments are for evaluation; you and your provider will have the opportunity to discuss treatment options at that appointment and to determine what course of treatment best works for you. Treatments may include medication management and/or counseling for the treatment of the distress you are experiencing.

All of your treatment at is kept confidential. No information will be released without your written consent unless your clinician feels you are a danger to yourself or others. Releasing information to any agency or individual will require a signed release of information. Please ask if you have further questions about our privacy policy.

I have read, understand and agree with the above informed consent statement. I have discussed any questions I have regarding my care with Iowa River Psychiatry and Counseling staff.

_____

Signature (client, parent or guardian as needed) Date

Iowa River Psychiatry and Counseling

585 West Cherry Street
North Liberty, Iowa 52317
tel: 319-665-4724 fax: 319-626-2856
email scottstuartmd@outlook.com

Patient Information and Office Policies

Welcome to Iowa River Psychiatry and Counseling. We are glad you chose to receive care from us. We are committed to providing treatment in a professional, courteous and timely manner.

Confidentiality: Your confidentiality is one of our highest priorities. We are required by law to provide you a copy of specific privacy policies. These policies were enacted under the legislation called HIPAA (*Health Insurance Portability and Accountability Act)*. You can find this information at *https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html* as well as a useful summary at *https://www.hhs.gov/sites/default/files/privacysummary.pdf?language=es*. This summary document is also on our website.

Insurance Payments: It is your responsibility to know who administrates your mental health benefits under your insurance policy. **Please contact your insurance company for authorization to receive treatment.** Insurance companies often require *preauthorization* for mental health related services. As a courtesy, we will make reasonable attempts to get authorization for your services through your insurance company. However, it is your responsibility to make sure you have authorization for your services through your insurance company. Insurance companies will often deny payment for services because there is not a preauthorization for the service. **You will be responsible for payment of all services that are not paid by your insurance company, including denials** due to a failure to obtain **preauthorization.** We are able to accept nearly all forms of insurance for treatment, but are NOT authorized to accept Medicaid insurance.

Payment of Services: You are responsible for the timely payment of all services rendered, even if health insurance will pay for a portion of the charges. It is our policy that the person who seeks treatment is responsible for payment of those services. Our policy is to charge $25.00 for any returned check. This charge will be included on your statement at the end of the month.

Scheduling and Keeping Appointments: If you are unable to keep an appointment for any reason, please email or call us as soon as possible. **Appointments not kept and not cancelled by closing the day before the appointment, will be assessed a "No Show Charge" of $50.** Keeping appointments is an important part of treatment as well as a necessary business practice. We will not charge for late cancellations due to weather.

Release of Information: Information will not be released without a signed release of information. Please ask us for a release for any individual or agency that you would like involved in your care. Any paperwork or correspondence that you need completed will require a signed release of information.

Prescription Refills: We require **72 hours** advance notice to call in prescriptions with no refills remaining and for writing scripts for controlled substances. If you have refills, please contact your pharmacy to request a refill.

Forms and Paperwork/Attorney Work: We charge for forms and paperwork/attorney work. Our primary business is to provide psychiatric care to our clients. Requests to process forms and manage paperwork/legal issues are part of the time we spend to provide you with high quality care. Fees associated with this work including but not limited to; attorney correspondence, interviews, depositions, copies of records, subpoenas, FMLA paperwork, insurance forms, and clinician time.

Emergency/After Hours: Working hours for Iowa River Psychiatry and Counseling are 9 AM to 5 PM Mondays through Fridays excluding holidays. **We do NOT have after hours emergency services.** If you have an emergency need for care after hours, please go to the nearest emergency room, or call 911. Local ER options include the University of Iowa Hospitals and Clinics (319-356-1616 or 319-356-2233) and Mercy Hospital (319-339-0300). Your provider will also review emergency procedures at your first appointment, and will work with you to determine a management plan for any emergency needs you may have during treatment.

Iowa River Psychiatry and Counseling is co-located with Physician's Clinics of Iowa (PCI) but is a separate entity. PCI does provide logistical support including scheduling and medical records but does not provide emergency services for our patients.

Signing below indicates that I have read, understand and agree to the policies in this document.

Signed:_____ Date:_____

Iowa River Psychiatry and Counseling
Patient Information

Please Print: Today's Date:_____

First Name:_____ MI:____ Last Name:_____ Nickname:_____

Social Security Number:_____ Sex: M [ ] F [ ] Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

Circle the number you would like to receive reminder calls at:

Home Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Work Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Cell Phone ( )_____ May we identify ourselves: Yes [ ] No [ ]

Single [ ] Married [ ] Widowed [ ] Divorced [ ] Partner [ ] Name of significant other:_____

Primary Care Physician:_____City/Clinic:_____

Referred to our office by:_____Relationship:_____

Emergency Contact:

Name:_____ Phone:_____Releationship:_____

Signature:_____Date:_____

If Patient is a Minor:

Father: Name_____Address:_____

Home Phone:_____ Cell Phone:_____Date of Birth:_____

Mother: Name_____Address:_____

Home Phone:_____Cell Phone:_____Date of Birth:_____

Guardian if not Father or Mother:

Name_____Address:_____

Home Phone:_____Cell Phone:_____Date of Birth:_____

Signature of Parent/Guardian:_____Date:_____

Iowa River Psychiatry and Counseling
Insurance Information

If the Subscriber ID# is different from the Subscriber Social Security # please make sure to give us the subscriber social security # and date of birth. Your insurance company requires this information when we call on your behalf to check on a claim.

Primary Insurance Name of Insurance Carrier: _____

Subscriber ID# _____ Group # _____ Relationship to Patient: _____

Subscriber Name: _____ DOB: _____

Subscriber Address: _____

Subscriber Social Security #: _____ Employer: _____

Secondary Insurance Name of Insurance Carrier: _____

Member ID# _____ Group # _____ Relationship to Patient: _____

Member Name: _____ DOB: _____

Member Address: _____

Social Security #: _____ Employer: _____

Guarantor Information:

Name: _____ Social Security # _____

Relationship to Patient: _____ Male ☐ Female ☐ DOB: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Employer: _____

Authorization:

I hereby authorize Iowa River Psychiatry and Counseling to furnish the insured's insurance company information, which said insurance company, may request concerning my present circumstances. I further authorize Iowa River Psyciatry and Counseling to release diagnostic information relative to my treatment, to a laboratory or hospital of my choice, for billing purposes only. I understand that I am financially responsible to Iowa River Psychiatry and Counseling for charges not covered by my insurance. I further authorize photocopies to be made of this authorization and assignment for attachment to any insurance form and authorize the insurance company to accept the photocopy. The authorization shall continue and be in force and effect until revoked in writing by me.

_____ _____

Responsible Party Date

Health Insurance Portability and Accountability Act (HIPAA)

I acknowledge that I have received information from Iowa River Psychiatry and Counseling regarding HIPAA and my rights regarding confidentiality and protected information.

Signed:_____ Date:_____

Iowa River Psychatry and Counseling
585 W. Cherry Street
North Liberty, IA 52317

CONSENT TO TREAT A MINOR

DATE: _____

PARENT/LEGAL GUARDIAN INFO

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE: _____ SS#: _____

I HEREBY AUTHORIZE:

The above named doctors or any doctors associated with the above named practice, and whomever he/she/they may designate as assistants, to administer the required care as deemed necessary to my (indicate relationship of child) _____

(Name of Child) _____

SIGNED: _____

WITNESSED: _____