We are committed to providing the highest quality care. Please take the time to answer the following questions and then read the office forms, which outline our policies and your responsibilities.

Medical Practice of Tejal Kaur, MD: Our practice is committed to providing high quality preventative mental health services to adults, teenagers, kids and families. We provide an initial consultation that includes a collaborative discussion on treatment planning. Treatment options can include comprehensive diagnostic evaluation, medication management, psychotherapy, family services, complementary treatments, school or work based consultation, and preventative health planning. We will pair you with one of our highly trained clinicians who we feel would be the best fit for your needs. Since we work as a team, regardless of whom you work with, our other clinicians will be involved in your treatment, either through direct care or input into your treatment planning.

Initial Consultation: Your first appointment(s) will be an evaluation. This follow up meeting includes a discussion about our impressions of the presenting problem and our recommendations. If you require care that is not provided by Dr. Kaur or one of her associates, you may be referred to another care provider after the evaluation. A doctor-patient relationship is established only once a client is accepted into the practice by Dr. Kaur.

Communication Policy: Our main office can be reached by phone at (917) 740-5287 or by fax at 1-888-396-3996. Electronic communication is possible by opting in through an electronic communication consent. We will respond to communication from existing patients within one business day.

Insurance: Our office is out-of-network for insurance companies. You are responsible for paying your bill in full. You are also responsible for collecting from insurance any portion of your bill that is covered by your insurance. On your request, we will send you statements that you may send to your insurance company to request any reimbursement for which you may be eligible.

Cancellation Policy: Appointments may be canceled with <u>at least 48 hour notice</u>. If one cancels their appointment 48 hours or less prior to the appointment, misses their appointment, or is late to their appointment, the client is still responsible for the FULL FEE of the appointment, <u>regardless of the need for cancelation or lateness</u>. Please remember, we do not double book, and so when you have scheduled an appointment, you are charged for the time reserved for your session, whether or not you attend the session.

Billing: It is required to leave credit card information for charging appointments, including missed appointments. Billing is done by credit card, and is due in full by the time of service. Your card is typically charged sometime within the 48 hour period prior to your appointment.

<u>Fees:</u> Fees vary by type of service, length of service, and clinician providing the service. Fees increase by 2.5% on January first of each year (after you have been in our practice for at least 1 year).
If needed, please do ask for financial assistance. Fees can be decreased based on financial need and based on current availability in practice. Please be prepared to detail financial status if making a request for fee reduction.

Standard Services Included in Session Fee:
Office visits may include evaluation, assessment, psychotherapy, family sessions, medication management, treatment planning, and/or discussion of treatment options. Certain post/pre-visit work is included in the session fee: email communication with patients about scheduling, brief phone check-ins about medication (when clinically indicated and not in-lieu of scheduled session), urgent telephone calls, electronic delivery of educational resources to patient, review of patient records/calls to prior clinicians, communication with patient's current treatment team, order and review of psychiatric lab tests, session documentation, maintenance of patient medical record, routine referrals, and production of CPT coded receipts.

Fees for Special Services: Rates and fees are based on time (prorated or every 15 minutes based on fee for 45 minute therapy session). Special services include prolonged telephone calls (more than 10 minutes); calls or meetings with patient's family members, school or work; special document work, intensive record review, medication refills (requested outside of sessions/due to missed session). For any other matters that require time outside of sessions, we also reserve the right to bill. Special services are often NOT "covered" by out-of-network insurance reimbursement, but patient is still responsible for payment.

Current Fees:

Appointments with Psychiatrist (MD)
Psychiatric Evaluation/Consultation (up to 90 minutes): $700
Psychiatric Evaluation/Consultation (up to 60 minutes): $500
Follow-up:
Medication: $400 (typically 30 minute appointments)
Medication: $450 (typically 45 minute appointments)
Therapy: (with/without psychopharmacology): $400 (typically 45 minute weekly appointments)

Appointments with Nurse Practitioner (NP)
Psychiatric Evaluation/Consultation (up to 90 minutes): $250

Follow-up:
Medication: $200 (typically 30 minute appointments)
Medication: $225 (typically 45 minute appointments)
Therapy: (with/without psychopharmacology): $200 (typically 45-minute weekly appointment)

Tejal Kaur, M.D.

Consent for Treatment:

I, _____, consent to psychiatric evaluation and treatment by Dr. Kaur, or one of her associates, if I am accepted into the practice. I understand that she does not, and cannot, guarantee any specific results.

Client's name_____

Client's (or legal guardian's) signature:_____

Name of Signee (if other than patient):_____

Relationship to Client:_____ (self, parent, legal guardian)

Date: _____

ACCEPTANCE OF POLICIES:
You are encouraged to ask questions before signing.
By signing below, you acknowledge that you have read, understand, agree with, and will abide by all policies.

Print Name_____ Date_____

Signature_____

Billing:

Credit card information is used for regular billing and billing of late cancellation or missed appointments. Your card will usually be charged 48 hours prior to the time of the scheduled visit.

Credit Card (circle): Visa Mastercard Discover

Name on Card_____

Number:_____-_____-_____-_____

Billing Street Address _____ Billing Zip code _____

Expiration Date_____/_____ Code_____ (3 digits on back of card)

I hereby authorize Tejal Kaur, MD to charge my credit card for services rendered (or for charges due to missed appointments) with the above credit card. I acknowledge and agree that Tejal Kaur, MD may charge this card, or another card I provide at another time in lieu of this card, on an ongoing basis, unless and until such authorization is revoked by me in writing.

Authorized Signature_____

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PHONE: 917-740-5287 FAX: 888-396-3996

CLINICAL PRACTICE: NOTICE OF PRIVACY PRACTICES

The HIPAA Privacy Rule, a Federal law, gives you rights over your health information and sets rules and limits on who can look at and receive your health information. The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral. The Security Rule, a Federal law that protects health information in electronic form, requires entities covered by HIPAA to ensure that electronic protected health information is secure.

WHAT INFORMATION IS PROTECTED

- Information we put in your electronic medical record
- Conversations we have about your care or treatment with others
- Billing information about you at our office
- Most other health information about you that we hold

HOW IS THIS INFORMATION PROTECTED

By law we are required to insure that your protected health information (PHI) is kept private. Documentation for your visit will include notes of your initial psychiatric assessment, a brief entry at each subsequent visit indicating current status, any salient information or laboratory results, and any medication(s) prescribed. There may also be periodic summary statements that are concise and provide a general description of treatment progress. More detailed psychotherapy notes may or may not be recorded at each of your office visits, but these are kept separate from the documentation of the visit, as described above.

We will reasonably limit uses and disclosures to the minimum necessary to accomplish their intended purpose. Most routine uses and disclosures of health information fall into three main categories: treatment, payment and health care operations. Additionally, we may use or disclose the minimum necessary information as required by the law. This includes disclosures regarding potential for harm to oneself or others, suspicion of child or elder abuse, or abuse of persons with mental retardation.

Psychotherapy notes are not necessarily made routinely and consist of a clinician’s notes to themselves documenting or analyzing the contents of conversation during a private counseling session, for the purpose of understanding your case and following up your progress in treatment; they are not part of your medical record. With your additional request and authorization in writing, the specific content of psychotherapy notes about your treatment may be disclosed, but only at our discretion and after discussion with you, except under the following specific circumstances in which we may use or disclose any information, without your consent or authorization:

- For our own training in consultation with other members of our profession. In these instances your personal identifiers will not be revealed so as to maintain anonymity.
- For us to defend ourselves in a legal proceeding brought by you
- For HHS to investigate our compliance with privacy rules
- To avert a serious and imminent threat to public health and safety
- To a health oversight agency for lawful oversight of me
- For the lawful activities of a coroner or medical examiner
- If an Institutional Review Board/Privacy Board approves a waiver of authorization for disclosure
- To comply with laws relating to workers' compensation or other similar programs
- For any other reason as required by law or legal process

WHAT RIGHTS DOES THE PRIVACY RULE GIVE YOU OVER YOUR HEALTH INFORMATION

We will comply with your right to:

- Ask to see and get a copy of your health records
- Have corrections added to your health information
- Receive a notice that tells you how your health information may be used and shared
- Decide if you want to give your permission before your health information can be used or shared for certain purposes
- Get a report on when and why your health information was shared for certain purposes
- Ask to be reached somewhere other than home
- If you believe your rights are being denied or your health information isn't being protected, you can file a complaint with me, or with the U.S. Government, at the website at www.hhs.gov/ocr/privacy/hipaa/complaints/

SUMMARY

With your consent, we will use confidential medical records for the purposes of treatment, payment and health care operations. With the exceptions noted above, further authorization in writing will need to be obtained for all other uses of your protected medical information by us.

I have received and reviewed a copy of this Notice of Privacy Practices:

Signature: _____ Date: _____

Patient Name: _____ DOB of patient: _____

Name of Signee (if other than patient):_____

Relationship to Patient:_____ (self, parent, legal guardian)

TEJAL KAUR, MD

Consent for Electronic Communication

Electronic communication is not a suitable forum for communication of emergencies or crisis situations. Email, and other forms of electronic communication, may not be checked regularly and may not be received. By e-mailing, texting, or video chatting (ie Skype, Facetime, Google Hangout) with Dr. Kaur, or her associates, you are consenting to electronic communication with the understanding that the security of information delivered using technology carries risks to confidentiality (privacy) and security. During the course of your treatment, you may choose to communicate through these methods for your convenience, however, none of the above methods provide encryption. It is recommended you never use your employer's emails service for your personal communications. The most secure ways to communicate electronically with your clinician would be through the Patient Fusion Portal, by fax, or through a shared cloud folder (invitation may be sent by our clinicians- please request).

I have received and reviewed a copy of this Consent for Electronic Communication, and I acknowledge that the security of information delivered using technology such as email, text message, Skype, Google Hangout, and Facetime cannot be guaranteed by Tejal Kaur, MD, and that such forms of communication may carry inherent risks with data security. I acknowledge that I am not required to communicate with my clinicians by email, text, or video chat (ie Skype, Google Hangout, or Facetime), and if I choose to do so, I am assuming the risk inherent in these forms of communication. I also acknowledge that I have been notified that should I choose to communicate electronically using technology with a greater degree of patient securities in place, I may communicate with my clinician through the Patient Fusion Patient Portal. I acknowledge that I am aware that documents that need to be shared securely between patient and clinician may alternatively be sent by secure fax to 1-888-396-3996 or may be uploaded into a secure online folder (by request from your clinician).

Signature: _____ Date: _____

Patient Name: _____ DOB of patient: _____

Name of Signee (if other than patient):_____

Relationship to Patient:_____ (self, parent, legal guardian)

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