Stephens Psychiatry

Jeff Stephens, MD | Cara Reeves, PhD

Demographics

Patient Information:

First Name: **Middle:** **Last:** **DOB:**

Preferred Name: **Gender:** **Pronouns:**

Primary Phone: (receives apt reminders):

Secondary Ph: **Email:**

Address: **City:** **State:** **Zip Code:**

Emergency Contact Information:

****If under the age of 18 list parents/guardians we are allowed to communicate with about care****

Name: **Relationship:**

Phone: **Email:**

Guarantor Information (this person is responsible for paying for sessions):

Name: **Relationship:**

Phone: **Email:**

Preferred Pharmacy:

Local Pharmacy: **Phone:**

Street Address:

Drug Allergies:

Signature: **Date:**

Relationship to Patient: **Name of Authorized Representative:**

Ph: 864-520-1133 | Fax: 864-520-1124 | Email: stephenspsychiatry@gmail.com

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Authorization for Release of Information

Patient Name: _____ **Date of Birth:** _____

Release/Obtain Records: (Who/Where we may receive/release records)	**Name of Individual/healthcare provider/hospital/practice:** _____ Phone: _____ Fax: _____
Purpose of Release: (Why is it needed):	☐ Continuity of care ☐ Patient's request ☐ Legal, disability, insurance purposes ☐ Other
Types of Records (What can be released?)	☐ All Records ☐ Mental health evaluations ☐ Developmental and/or social history ☐ Progress Notes, and treatment summary ☐ Other
Treatment Dates to be Released:	☐ All Treatment Dates ☐ Treatment Dates from _____ to _____
Family/Friends/ Caregivers: (please list all that we would have permission to speak with, including BOTH parents)	1. Name: _____ Relationship: _____ Phone: _____ 2. Name: _____ Relationship: _____ Phone: _____ 3. ☐ **Release my information to no one other than myself.**

Please read and check the following before signing:

☐ I understand this authorization may be revoked at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified, unless the physician specified above is otherwise notified by me.

☐ I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and/or drug dependency. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42CFR Part2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

Signature: _____ **Date:** _____

Relationship to Patient: _____ **Name of Authorized Representative:** _____

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Financial Policy

Patient Name: _____ **Date of Birth:** _____

1. Payment is due at the time of service. If there are questions about charges, please inquire when scheduling your appointment.

2. Fees:

Description	Jeff Stephens, MD	Cara Reeves, PhD
New Patient Visit	$350	$300
10 – 15 Minutes	$100	-
15 – 20 Minutes	$125	-
30 – 35 Minutes	$175	-
40 – 55 Minutes	$250	$180
60 Minutes	$350	-

a. There is a $50 non-refundable deposit is due for new patients when scheduling that will go toward the total cost of the appointment.

b.There will be a fee for all letters, disability/FMLA forms, school forms, etc at the providers discretion.

3. Methods of payment: You may pay your bill with cash, check, or credit card. For your personal convenience we accept Visa, Mastercard, Discover, and American Express. Our credit card system does charge a 3.5% processing fee to you, the customer, to use a credit card. There is no fee to use a debit or HSA card.

4. Returned checks: a $30 service charge will be added on all returned checks for insufficient funds.

5. No Show Fees: You will be charged ½ of the appointment cost for missed appointment without any notice of cancellation. We provide a reminder email, text, and call for appointments as a courtesy. No show fees must be paid prior to rescheduling appointment.

6. Special needs: We realize that temporary financial problems may make it difficult to pay your balance immediately. If such problems should arise, please contact us promptly so that we may set up a payment plan that will meet your needs. We are willing to work with you on your account in temporary circumstances, but it is your responsibility to communicate and inform us of any reason you are unable to pay at the time of service.

7. Collection Policy: Delinquent accounts will be forwarded to a collection agency. We will inform you of your account status on your statement and we will attempt to contact you by letter before your account is forwarded. If you are unable to pay your balance promptly, please call so that we can arrange payment plan and hold your account from collections. Unpaid balances may also result in discharge from the practice.

Signature: _____ **Date:** _____

Relationship to Patient: _____ **Name of Authorized Representative:** _____

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Payment Authorization Form

Patient Name: _____ **Date of Birth:** _____

Card Information:

Name on Card: _____ **Is this an HSA or FSA?** _____

Card Number: _____ _____ _____ _____

Expiration Date: _____ **Security Code:** _____ **Billing Zip Code:** _____

- **I hereby authorize Stephens Psychiatry to charge this card for services rendered and any balances including session fees, administration fees, and no-showed appointments.**
- I authorize Stephens Psychiatry to charge my credit card through CARDX. I understand that there is no fee for me to use a debit card, and there is a 3.5% processing fee for me if I use a credit card.
- The card processing system will automatically recognize the card for what it is, debit or credit.
- I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Stephens Psychiatry in writing of any changes in my account information or termination of this authorization.
- I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form. I acknowledge that credit card transactions could be linked to Protected Health Information.
- I verify that the credit card information provided above is accurate to the best of my knowledge. If this information is incorrect or fraudulent, or if my payment is declined, I understand that I am responsible for the entire amount owed and any additional costs incurred if denied

Signature: _____ **Date:** _____

Card Holder Name: _____

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Controlled Substance Agreement

Patient Name: _____ **Date of Birth:** _____

I understand and agree to the following:

1. I agree to closely follow the treatment plan developed by my provider with open communication about my medical conditions; including the effect on my daily life, how well my medications are helping, side effects, medications received from other providers, drug/alcohol misuse/addiction, or if I become pregnant or am nursing.
2. I agree to take my medications as prescribed without increasing or discontinuing my medication without talking to my provider first. I understand that the renewal of my prescription depends on my medical condition, my consistent participation and my adherence with my treatment plan and this agreement.
3. I agree that if it is believed to be no longer medically necessary my provider may taper and stop my medication. I know that withdrawal symptoms are normal and to be expected.
4. I will not share, sell, trade, give away, or otherwise misuse my prescription medications.
5. I will not alter any prescriptions provided to me by my provider.
6. If my prescription is lost, stolen, or damaged it will not be replaced or refilled early. I understand that it is my responsibility to keep my medications in a safe and secure place.
7. I understand that if I attempt to receive controlled substance prescriptions from another provider, no further refills will be given and I may be discharged from the practice.
8. I understand that it is my responsibility to keep and/or reschedule my appointments with my provider. I will call and reschedule my appointments if I cannot keep them. Missing multiple appointments may result in medications not being refilled and/or discharge from the practice due to non-compliance.
9. If my provider has to reschedule, postpone, or cancel my appointment my provider will determine if my prescription can be refilled.
10. If I break this agreement, my provider or any other provider within this office will not give any refills of this or similar medications and I may be discharged from this practice.
11. This agreement does not guarantee prescription of controlled substances.
12. This agreement does not keep me from seeking emergency medical treatment or receiving pain management related to a surgery or injury.

Signature: _____ **Date:** _____

Relationship to Patient: _____ **Name of Authorized Representative:** _____

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Notice of Privacy Practices

Our Legal Duty

I am required by applicable federal and state laws to maintain the privacy of your Protected Health Information (PHI). I am also required to give you this notice about our privacy practices, my legal duties, and your rights concerning your PHI. I must follow the privacy practices.. I reserve the right to change our privacy practices and the terms of this notice at any time, provided that such changes are permitted applicable law. I reserve the right to make the changes in my privacy practices and the new terms of our notice effective for all PHI that I maintain, including medical information I created or received before I made the changes. You may request a copy of our notice (or any subsequent revised notice) at any time.

Uses and Disclosures of Protected Health Information Without Your Authorization

In certain situations, which are described in the **Uses and Disclosures Based on Your Written Authorization** Section below, I must obtain your written authorization in order to use and/or disclose your PHI. However, unless the PHI is considered Highly Confidential Information and the applicable law regulating such information imposes special restrictions on me, I may use and disclose your PHI without your written authorization for the following purposes:

Treatment: I will use and disclose your PHI to provide, coordinate or manage your health care and any related services. This includes the coordination or management of our health care with a third party. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, I may disclose your PHI from time to time to another healthcare provider for the sake of consultation. In these select cases, I will make every effort to withhold any identifying information.

Payment: Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may request before it approves or reimburses for the health care services I recommend for you, You have the right to restrict disclosure of PHI to health insurance companies if the you pay out-of-pocket in full for the health care service.

Health Care Operations: I may use or disclose, as needed your PHI in order to conduct certain business and operational activities. These activities include, but are not limited to, quality assessment activities, licensing, and conducting or arranging for other business activities. For example, I may call you by name in the waiting room. I may use or disclose your PHI, as necessary, to contact you by telephone or email to remind you of your appointment.

Business Associates: I may share limited PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between my office and a business associate involves the use or disclosure of your PHI, I will have an agreement that contains terms that will protect the privacy of your PHI.

Research; Death; Organ Donation: I may use or disclose your PHI for research purposes in limited circumstances. I may disclose the PHI of a deceased person to a coroner, protected health examiner, funeral director or organ procurement organization for certain purposes.

Public Health and Safety: I may disclose your PHI to the extent necessary to avert a serious and imminent threat to your health or safety, or the health or safety of others. I may disclose your PHI to a government agency authorized to oversee the healthcare system or government programs or its contractors, and to public health authorities for public health purposes.

Health Oversight: I may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: I may disclose your PHI to a public health authority that is authorized by law to receive reports of child, elder, or some disabled individuals abuse or neglect. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: I may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations; to track products; to enable product recalls; to make repairs or replacements; or to conduct post marketing surveillance, as required.

Criminal Activity: Consistent with applicable federal and state laws, I may disclose your PHI if I believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. I may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Required by Law: I may use or disclose your PHI when I am required to do so by the law. For example, I must disclose your PHI to the U.S. Department of Health and Human Services upon request for purposes of determining whether I am in compliance with federal privacy laws. I may disclose your PHI when authorized by workers' compensation or similar laws.

Process and proceedings: I may disclose your PHI in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant or grand jury subpoena, I may disclose your PHI to law enforcement officials.

Law Enforcement: I may disclose limited information to a law enforcement official concerning the PHI of a suspect, fugitive, material witness, crime victim, or missing person. I may disclose the PHI of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances. I may disclose PHI where necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.

More Stringent State and Federal Laws: Federal law under HIPAA preempts state laws that are in conflict with Privacy Rule requirements or those that provide *less stringent* privacy protections.

Those states that have *more stringent* privacy laws would preempt Federal law. Certain federal laws also are more stringent than HIPAA. I will continue to abide by these more stringent state and federal laws. **More Stringent Federal Laws:** The federal laws include applicable internet privacy laws, such as the Children's Online Privacy Protection Act and the federal laws and regulations governing the confidentiality of health information regarding substance abuse treatment.

Uses and Disclosures Based on Your Written Authorization

Other uses and disclosures of your PHI will be made only with your authorization, unless otherwise permitted or required by law as described below. You may give me written authorization to use your PHI or to disclose it to anyone for any purpose. If you give me an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Without your written authorization, I will not disclose your healthcare information except as described in this notice.

Uses and Disclosures of Your Highly Confidential Information: Federal and state law requires special privacy protections for certain health information about you (Highly Confidential Information), including AIDS/HIV records,

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Alcohol and Drug Abuse Treatment Program records, and other health information that is given special privacy protection under state or federal laws other than HIPAA.

Your Rights

Access: You have the right to review or receive copies of your PHI, with limited exceptions. You must make a request in writing to receive copies of your PHI. Copies of records are billed at $0.50 per page. This includes administrative time to complete the request and any postage required for mailed copies. If you prefer, I will prepare a summary or an explanation of your PHI for a fee. Contact me using the information listed at the end of this notice for a full explanation of our fee structure.

Accounting of Disclosures: You have the right to receive a list of instances in which I or my business associates disclosed your PHI for purposes other than treatment, payment, health care operations and certain other activities. I will provide you with the date on which I made the disclosure, the name of the person or entity to which I disclosed your PHI, a description of the PHI I disclosed, the reason for the disclosure, and certain other information. If you request this list more than once in a 12-month period, I may charge you a reasonable, cost-based fee for responding to these additional requests.

Breach Notification: When I become aware of or suspect a breach of your PHI, I will conduct a risk assessment. I will keep a written record of that risk assessment. (2) Unless I determine that there is a low probability that PHI has been compromised, I will give notice of the breach to all affected parties. (3) The risk assessment can be done by a business associate if I was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, I will provide any required notice to patients and HHS. (4) After any breach, particularly one that requires notice, I will re-assess its privacy and security practices to determine what changes should be made to prevent the re-occurrence of such breaches.

Amendment: You have the right to request that I amend your PHI. Your request must be in writing, and it must explain why the information you want amended or for certain other reasons. If I deny your request, I will provide you a written explanation. You may respond with a statement of disagreement to be appended to the information you want amended. If I accept your request to amend the information, I will make reasonable efforts to inform others, including people or entities you name, of the amendment and to include the changes in any future disclosures of the information.

Questions and Concerns: If you want more information about my privacy practices or have questions or concerns, please contact me using the information below. If you believe that I may have violated your privacy rights, or you disagree with a decision I made about access to your PHI or in response to a request you made, I encourage you to share this with us directly with using the contact information below. Further, you may file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints.** I will not retaliate in any way if you choose to file a complaint.

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Consent For Treatment

Psychiatric Services: Depending on your individual needs and desires, and the scope of work of your clinician, the services that we provide may include psychiatric evaluation, medication management, and treatment. During our work together, we will engage in active discussion regarding the services that we will and can provide and collaboratively determine an appropriate plan for your care. It is important to note that all psychiatric services can come with both risks and benefits. Benefits may include improvements in the areas in which you are seeking my services, improved wellbeing, and improved mental health. Due to the variety of factors that impact outcomes, no specific outcomes can be guaranteed at the outset of treatment. Potential risks of engaging in these services include increased distress, when addressing challenging aspects of your life and risks of potential side effects of medical treatments if recommended/provided. I will explain to you the specific rationale, risks, and benefits of my recommendations through this process and will invite your questions and ideas. It is my responsibility to monitor and assess for tolerance as well as benefit of such treatments. I will rely on you to share your concerns and progress openly during our visits. As we progress through treatment, I may recommend various interventions, structured assessment tools, or make referrals to other care providers.

Medications: If appropriate, I may prescribe medications as part of your treatment. As with any treatment protocol, psychiatric medications may cause side effects. I will discuss the specific known side effects and possible benefits of any medication that may be indicated. Every individual is unique and responds differently to medications. If you begin to experience anything you believe may be a side effect or interaction, please notify me as soon as possible.

It is your responsibility to keep track of the amount of medication and the total number of refills you have remaining so that you do not unexpectedly run out of medication. It also your responsibility to ensure that your medication is maintained in a secure manner to avoid theft or inadvertent ingestion by a third party. Any request for replacement of medication due to destruction, theft, or other loss, will be predicated on planning to prevent such future losses. For controlled medications I will only offer a replacement once.

In order to best assess potential adverse impacts on your health including, but not limited to, medication interactions, you must inform me whenever another provider prescribes you a new medication or other therapeutic agent. It can be very harmful for you to discontinue or alter the dosing of your medication without the guidance of a qualified healthcare provider. If you feel that your current medication and/or dosage is not appropriate, please let me know.

If you are requesting refills of non-controlled substances, please call your pharmacy directly. If you are requesting a refill of a controlled substance, I am required to see you in person no less than once every three months. Please refer to the "Contact Outside of Sessions" section of this document for additional information about your privacy when communicating via email.

Psychiatric Appointments: Our work together will involve regular meetings together at pre-arranged times. Our first session will begin with a 60-minute intake evaluation which will allow us to discuss in depth your history, important aspects of your experience, and reason for seeking care. We will begin formulating a treatment plan and discuss medication management, if indicated, in this session as well. Subsequent sessions will occur at a frequency we determine together. If you arrive late to our sessions, I am glad to see you for the time remaining in our pre-scheduled session. However, if you arrive 10 or more minutes late, we will need to reschedule. If I am late for any reason, I will discuss with you options and make every effort to extend our time in that or a subsequent session.

Missed Session/Late Cancellations: If you have 3 no-show appointments, 3 late cancellations, or 3 visits to which you've arrived late, you may be discharged from the practice for noncompliance.

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Contact Outside of Sessions: You are welcome to send emails outside of our session times to communicate regarding scheduling or other logistical or non-urgent medical issues. I will endeavor to respond as soon as I am able, but please note that the timing may be variable. Please be aware that email is not a consistently secure form of communication, and I cannot guarantee your privacy via unencrypted email. Please do not send confidential information via email. If you communicate private information via unencrypted e-mail, e-fax, or voicemail, I will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted. Email and voicemail messages are not a substitute for in person or telehealth visits.

Emergency Services: I do not offer emergency services as we are an outpatient clinic. If you are experiencing an emergency of any kind including but not limited to suicidal thoughts, self-harm, homicidal thoughts, medication reaction, inability to feel safe, please contact 911, go to a local emergency room, and/or contact the below entitles.

Carolina Center for Behavioral Health – 864-235-2335

Suicide and Crisis Lifeline – 988

Do not leave a message for me, as I cannot guarantee when I will hear or see it.

Termination of Services: As noted above, we will discuss throughout our work together the progress you are making toward your goals and the ongoing risks and benefits of any treatment interventions and recommendations. I consider it both of our responsibility to discuss openly if there are concerns about your ability to benefit from our work. There may come a time when your needs may change or be better served by a different professional, service, or approach. At such a time, I may provide referrals to you if I deem this to be in your best interest. You have the right to discontinue our treatment together at any point. If you choose to discontinue treatment, I ask that you discuss this with me. Due to the nature of services, a sudden discontinuation of treatment may be harmful to you, and I want to minimize any potential harm. Please provide me with as much notice as is feasible about your plans to discontinue our work together.

CONSENT FOR TREATMENT and ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:

☐ I hereby give consent to treatment and/or medication. I authorize/ consent to Stephens Psychiatry the release of medical information, including MH/SA to Stephens Psychiatry personnel for coordination of care. I hereby authorize/consent that I understand the policies of Stephens Psychiatry and agree to abide by them. Additionally, I have received a copy of Stephens Psychiatry Notice of Privacy Policies.

Signature: _____ **Date:** _____

Relationship to Patient: _____ **Name of Authorized Representative:** _____

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