Cary Psychiatry

Cary Psychiatry
1616 Evans Rd, St 105
Cary, NC 27519
Phone: 919-378-9761
Fax: 919-234-0494

OFFICE POLICIES

Informed Consent for Psychiatric Services
It is our pleasure to have the opportunity to work with you. Please read this document carefully. It contains important information about our professional services and business policies. Before signing, please feel free to ask us any questions. Once this document is signed, it will constitute a binding agreement between you and Cary Psychiatry.

Services
Dr. Mikel is a licensed Psychiatrist in the state of North Carolina. As a physician, Dr. Mikel can prescribe medication if both parties agree this is a necessary and appropriate treatment. Maggie Evers and Katherine Myers are certified Physician's Assistants. The providers may recommend psychotherapy either alone, or in addition to medication. All treatment requires an active effort on your part. After your initial assessment, the providers will offer you some impressions of what our work may entail and possible treatment recommendations.

If at any time you have questions regarding your treatment plan, please feel free to discuss them with your provider.

Confidentiality
Trust and safety are paramount in the treatment of your mental health. Therefore, I take confidentiality very seriously. However, there are a few exceptions:

1. If I believe you could harm yourself or others
2. If I suspect child or elder abuse
3. If a court subpoenas your records
4. If an on-call physician needs information to treat you appropriately in my absence.
5. If you verbally consent for me to release or request documents with another provider to optimize your care.

Questions, Concerns and Emergencies
During business hours, please contact our office at (919) 378-9761, admin@carypsychiatrycenter.com, or via portal message. After business hours or the case of extreme emergency, please call 911, or seek immediate care at your nearest emergency department.

Prescription Refills
If you begin taking a medication it is very important that you are safely monitored for its effectiveness and side effects. You will be given ample medication and refills until your next appointment. *It is your responsibility to schedule follow-up appointments before you run out of your prescription.* In return, you will find that we are conscientious about the cost of medical care and do not request unnecessary visits. If we do refill a medication between visits, it is usually our policy to prescribe only enough medicine until the next visit. When requesting a prescription refill, please give your provider **at least 48** hours to complete your request.

Contacting You

It is your responsibility to keep your contact information up to date. If your information changes, please contact our office at (919) 378-9761 and update our staff as soon as possible.

Contacting Me

We encourage you to contact the office if you have questions or concerns about your treatment. We will make every effort to return your call within the same day, but it may be the next day on occasion. It is easiest to reach the doctors directly via messaging or email. You may call the office during office hours and leave a non-confidential voicemail or message with my administrative managers. Please identify if it is an emergency or if you need a rapid call return. **We strongly encourage use of our portal messaging**. Please allow 48 hours for a response. This is an encrypted message service and is secure for private communications. If you elect to email through the Gmail account, you understand that the messages are standard email and not considered secure.

Insurance

We are an in-network provider for BCBS, United Optum, and Cigna. For all others, we will provide you with the necessary information to file your claim with your insurance company. **You will be responsible for communicating with your insurance company for their reimbursement policy**.

If your insurance claim is denied for any reason other than a coding error, we will resubmit the claim once. After two denials, the claim becomes patient responsibility.

Payment and Fees

- Initial evaluations are $325 and follow-up appointments are $175.00, for our self-pay clients. For our insured clients, the price of visits will depend on your individual plan and may take the form of co-pays, co-insurances, or deductible amounts. Payment is due in full at the time of service. Cary Psychiatry does **NOT** bill. If we take your insurance and if you have an unmet deductible that exceeds the amount of the visit, the cost of the visit will be collected at the visit and receipt of payment will be submitted to your insurance company.

- We are happy to fill out various forms for our clients. All forms must be completed during your appointment time, to ensure that both our clients and our providers agree to the terms and conditions laid out in the form. There is a $50 forms fee, this fee is not an insurance billable charge and is client responsibility.

- We will strive to complete all work during our scheduled sessions. We may charge a **$50 fee for** other professional services you may require such as report writing, telephone conversations lasting longer than 10 minutes, prior authorizations, and consultations with other professionals that you have requested. Our office accepts cash, check, Health Savings Account, Flex Spending Account, and Visa, MasterCard, Discover. There is a **$35** charge for any checks that are returned unpaid by your bank.

Cancellations and Missed Appointments

1. We will make every effort to respect your time and to run our practice on time. You can help by showing up 5-10 minutes before your appointment time. If you are on a tight schedule, please notify the administrative assistant when you check-in.

2. Cancellations must be made 24 hours in advance (Friday for a Monday appointment) by calling my office or sending a message through the secure portal except in the event of emergency, please notify as soon as possible. There is a **$175 fee** for all follow up appointment **no call no-shows**. For New Patient appointments there is a **$325 fee for no call no shows.** Repeated no-shows or late cancellations will be carefully discussed and may result in a discharge from our practice.

3. If you are more than 15 minutes late for a 30 min appointment, you may be asked to reschedule depending on whether there are patients scheduled immediately after you.

Again, we appreciate the opportunity to be of service to you. If you have any questions, concerns, or suggestions regarding the practice, please discuss them with us. We always eager to hear your comments and will gladly answer any questions.

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NOTICE OF PRIVACY PRACTICES

IMPORTANT: THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Purpose of this Notice: We are required by law to protect certain aspects of your health care information known as **Protected Health Information or PHI** and to provide you with this Notice of Privacy Practices. This Notice describes our privacy practices, your legal rights, and lets you know, how we are permitted to:

- Use and disclose PHI about you
- How you can access and copy that information
- How you may request amendment of that information
- How you may request restrictions on our use and disclosure of your PHI.

In most situations we may use this information described in this notice without your permission, but there are some situations where we may use it only after we obtain your written authorization, if we are required by law to do so. We respect your privacy and treat all health care information about our patients with care under strict policies of confidentiality that all of our staff are committed to following at all times.

Uses and Disclosures of PHI: We may use PHI for the purposes of treatment, payment, and health care operations, in most cases without your written permission. Examples of our use of your PHI:

- **For treatment**. This includes such things as verbal and written information that we obtain about you and use pertaining to your medical condition and treatment provided to you by us and other medical personnel (including doctors and nurses who give orders to allow us to provide treatment to you). It also includes information we give to other health care personnel to whom we transfer your care and treatment, and includes transfer of PHI via radio or telephone to the hospital or dispatch center as well as providing the hospital with a copy of the written record we create in the course of providing you with treatment and transport.
- **For payment**. This includes any activities we must undertake in order to get reimbursed for the services we provide to you, including such things as organizing your PHI and submitting bills to insurance companies (either directly or through a third party billing company), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review, and collection of outstanding accounts.
- **For health care operations**. This includes quality assurance activities, licensing, and training programs to ensure that our personnel meet our standards of care and follow established policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes.

Use and Disclosure of PHI Without Your Authorization

We are permitted to use PHI *without* your written authorization, or opportunity to object in certain situations, including:

- For our use in treating you or in obtaining payment for services provided to you or in other health care operations;

- For the treatment activities of another health care provider;

- To another health care provider or entity for the payment activities of the provider or entity that receives the information (such as your hospital or insurance company);

- To another health care provider (such as the hospital to which you are transported or First Responder Agencies) for the health care operations activities of the covered entity that receives the information as long as the covered entity receiving the information has or has had a relationship with you and the PHI pertains to that relationship;

- For health care fraud and abuse detection or for activities related to compliance with the law;

- To a family member, other relative, or close personal friend or other individual involved in your care if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family, relatives, or friends if we infer from the circumstances that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when your spouse has called an ambulance for you. In situations where you are not capable of objecting (because you are not present or due to your incapacity or medical emergency), we may, in our professional judgment, determine that a disclosure to your family member, relative, or friend is in your best interest. In that situation, we will disclose only health information relevant to that person's involvement in your care.

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Medication Refill Policies

We do require office visits on a regular basis for all our patients taking prescription medication. The interval will vary depending on the type of medication prescribed. Per the state of North Carolina, patients taking controlled substances must be seen in the office ***every 3 months*** *to remain on the controlled drug. It is our goal to provide you enough refills on your medication until your next office visit.*

- It is your responsibility to notify the office in a timely manner when refills are necessary. It is important to keep your scheduled appointment to ensure that you receive timely refills.
- Please allow five (5) business days to call in for a refill of your prescription before you are about to run out. Approval of your refill may take up to three (3) business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.
- If you run out of your prescription sooner than your appointment this may result in denial of getting a refill until your next scheduled appointment
- Medication refills will only be addressed during regular office hours (Monday-Friday 9am-430 pm). Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or holidays, unless deemed necessary by your provider.
- Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment.
- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- If you have any questions regarding medications, please discuss these during your appointment.
- If for any reason you feel your medication needs to be adjusted or changed, please contact our front office staff and/or your provider immediately.

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Frequently Asked Questions

We understand that there might be a situation when you do have to call us for a prescription. Please review the list below and see what you can do to plan ahead.

Are you changing to a new local pharmacy? You should call your new pharmacy and request that your prescriptions be transferred from your old pharmacy. We sometimes do not have to write new prescriptions. However, controlled substances WILL NOT be transferred to a different pharmacy.

- Pharmacies may not always carry your specific medication and dosage, so medications may need to be special ordered by the pharmacy. If you need to change pharmacies for this reason, it will be handled on a case by case basis with your provider.

Are you going out of town and requesting to fill your prescription sooner? You need to call your pharmacy and our office and notify us of your circumstances. It is at the provider's discretion if they will honor your request to fill the prescription sooner.

Are you going on an extended vacation and need to use an out-of-town pharmacy? You need to call the NEW pharmacy that you will be using and have them contact your hometown pharmacy to see if your prescriptions could be transferred. When you return home, you must reverse the process. Often, the out of state pharmacy will need to contact our office before authorizing the medication fill.

- Please be aware that laws vary between states and we cannot guarantee you prescriptions will be filled in another state.

Are you changing to a new mail order pharmacy? Some pharmacies will transfer your prescriptions to the new pharmacy. If you still have refills on your current prescriptions, please check with your current mail order pharmacy to see if your prescriptions can be transferred.

If I missed my appointment, can I get refills of my controlled substances? Refills of controlled substances will not be authorized if an appointment is missed. We will bridge you with all non-controlled medications to last you through your next rescheduled appointment.

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OFFICE POLICIES ACKNOWLEDGEMENT

I have read and understand the office policies regarding financial arrangements, fees, and charges for missed appointments or late cancellations. I voluntarily consent to treatment and understand that informed consent ends with the termination of the professional relationship. I may terminate this relationship at any time.

Patient Name: ____ Birth Date: _________________

Patient/Guardian Signature: ____Date: _____________

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Privacy Practices Acknowledgement

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient Name: ____D.O.B: ____________

Patient/Guardian Signature: _____________________________________Date: ___________

PATIENT RECORDS DISCLOSURE

In general, the Health Insurance Portability and Accountability Act (HIPAA) privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner(s):

Preferred Phone: ____
☐Okay to leave message with detailed information
☐Leave message with call-back number only

Emergency Contact Phone: __________________________________
☐Okay to leave message with detailed information
☐Leave message with call-back number only

Patient Name: ____DOB: ____________

Patient/Guardian Signature: ____________________________________ Date: _____________

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Authorization for Release of Protected Health Information

I give permission for Cary Psychiatry to:

☐Release to ☐Receive from

Name of Doctor/Hospital/Facility: ____

Address: ____

City: ________________________________ State: _______ Zip: ______________

Phone: ___________________________ Fax: ______________________________

Information to be released: **Mental health and medical treatment records**

Purpose of disclosure: **Coordination of Care**

Patient Name: ____ D.O.B.____________

I authorize Cary Psychiatry (and staff members) to release the above designated information contained in my medical record. I understand that this may include treatment for physical and mental illnesses, alcohol/drug abuse, and/or HIV/AIDS results, diagnosis and/or treatment.

I understand that this authorization may be revoked by me (in writing) at any time except to the extent that action has been taken thereon. I understand that the information released may be subject to re-disclosure by the recipient. *This authorization expires in 1 year from date of signature below.

As a professional courtesy, no cost is assessed for information released directly to another health care provider; all other releases are subject to reasonable costs for copying and distribution.

Patient/Guardian Signature: ________________________________ Date: ____________

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CREDIT CARD ON FILE POLICY

At Cary Psychiatry, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.
Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

I authorize Cary Psychiatry to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

☐ Amex ☐ Visa ☐ MasterCard ☐ Discover

Cardholder Name: ____

Cardholder Phone Number: ____

Cardholder Address: ____

City ____ State__________ Zip _____________

Card Number: ____

Expiration Date: _____________ CVS Number: ___________

Signature: ____

I (we), the undersigned, authorize Cary Psychiatry to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.
This authorization relates to all payments not covered by my insurance company for services provided to me by Cary Psychiatry.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Cary Psychiatry in writing and the account must be in good standing.

Patient Name: ____ DOB: _______________

Patient/Guardian Signature: ____

Date: ____________________

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Preferred Pharmacy

Name: ____

Address: ____

Phone: ____

Allergies to Prescriptions

Do you have any know allergies ☐**NO** ☐**Yes**, please explain below

Drug Name	Reaction

Prescriptions

Medication Name	Medication Strength	Dosing Information

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CONTROLLED SUSBTANCE CONTRACT

Controlled substance medications (e.g. psychostimulants, benzodiazepines, etc.) are very useful but have a high potential for misuse and are, therefore, closely controlled by local, state and federal governments.

As a patient of Cary Psychiatry, I agree to the following:

1. I am responsible for the controlled substance medications prescribe me. If my prescription is misplaced, stolen or if I run out early, I understand that this medication **may not be replaced,** regardless of the circumstances. The only exception would be an emergency in which being without my medication would result in an adverse medical situation, and a refill is at the discretion of the provider.
2. I agree that I will obtain all my prescriptions for this/these medication(s) at **one** pharmacy
3. Refills of controlled substance medications:
    a. Will be made only during regular office hours, in person, at scheduled office visits unless otherwise noted and specified by the prescribing provider.
    b. Will to be made if a prescription is lost, misplaced, or finished early. I am solely responsible for taking the medication as prescribed and keeping track of the remaining supply.
    c. I understand that I must call ahead to schedule an appointment.
4. I agree to comply with urine testing and pill counts at every appointment, thereby, documenting the proper use of any medications.
5. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or fraudulently, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities, and I may be subject to dismissal from this practice.
6. I agree to comply with the treatment plan as prescribed by my physician.
7. I further understand that if I violate this controlled substance contract due to no-compliance of medical directions, such as, failure in taking the medications as prescribed, utilizing illicit substances, or abuse of controlled medications, I may be subject to dismissal from this practice.

I have been fully informed by Cary Psychiatry and my treating provider about the risks versus benefits of controlled substance medications. I agree to take all medications as prescribed and will only make changes to dose under medical supervision.

Patient Name: ____ DOB: _______________

Patient/Guardian Signature: _______________________________Date: ____________________