ORLANDO PSYCHIATRIC ASSOCIATES

ORLANDO: 2345 SAND LAKE ROAD, SUITE 200.
ORLANDO, FL 32809.
TEL: (407) 851-5121, FAX: (407) 851-0439

OCOEE:1551 BOREN DR. UNIT B. OCOEE, FL 34761
TEL: (407) 532-4940, FAX: (407) 532-4946

General Practice Policies

Appointment Policy

An appointment is considered a mutual commitment between you and your clinician, and is subject to personal accountability. Each patient/guardian is solely responsible for keeping and maintaining their appointments. A 48 (twenty-four) hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Appointments for which you arrive late will still end at the appointed time. We do not overbook or double book, so it is the patient/guardian's responsibility to manage the appointment and arrive during the scheduled window of time. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment. However, it is your responsibility for ensuring that we have the correct/current contact information and the responsibility for keeping your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling (if applicable) of the appointment. Initials_____

Payment for Services

OPA will directly bill your insurance company following your services. Your co-payment and ant deductibles and balances, which may apply, will be collected when you check-in. If we are not billing an insurance company for your service, the full payment is due at the time of service. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability.

Initials_____

Insurance reimburse only to diagnose and treatment of psychiatric disorders. Psychiatric evaluations for surgery, any other medical procedures, legal, educational, employment, immigration and disability purpose were not covered by your insurance. You will be considered as self pay patient and needs to be paid prior to see clinician.

Initials_____

OPA Charges for Self Pay Patient : Initial psychiatric Evaluation by Psychiatrist/ARNP/PA : $ 350

Medication Management follow up : $ 125

Therapist Initial Evaluation: $ 125

60 minutes therapy follow up: $ 90

Completion of forms such as FMLA, Educational, Short term/ Long term /Social security disability will be charged $ 150 per set. There will be a charge $ 50 for short/ one page version of forms. Initials_____

Treatment Issues

Our office staff will take messages during regular business hours. Please allow 24 to 48 (business) hours for a response, as clinicians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We are able to address routine concerns much more effectively than crisis concerns. If your concern involves a safety issue, please notify the front desk so that your clinician can be paged. If you have an after-hours concern, you may leave a message on our voicemail. If your need is an emergency due to safety issues after-hours, please call 911 or go to the nearest Emergency Department. Initials_____

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Dismissal

If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your physician/therapist. You have to find a physician/therapist in another practice. We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will assist you with care options. We will forward a copy of your medical records to your new physician when a release is received. Common reasons for dismissal include (but not limited to): Failure to keep appointments, frequent no-shows, Non-compliance (failure to follow clinicians instructions), Abuse (verbal or physical) to staff, Failure to pay for services rendered. Initials_____

Drug Testing

Here at OPA , We preform mandatory urine test on **ALL NEW PATIENTS** ages 13 years and older and random testing on existing patients and the fee for this will be $25.00 per test . Insurances will; not cover this charge and it will have to be paid by the patient. Initials_____

Consent

I have read and understand these policies in their entirety and agree to abide by these terms. I am also aware that if I have questions about these policies, I am encouraged to bring them to OPA's attention.

Please indicate your agreement to the terms of this policy by signing below: **Date_____**

Printed Patient Name_____

Signature of Patient_____

Printed Name of Responsible Party (if not patient) _____

Signature of Responsible Party_____

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Confidentiality Policy

The clinic operates in a "multi-disciplinary" way, meaning that the clinicians function as a team. Therefore, it is important to understand that the information in the charts is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicide or homicide issues or child/elder abuse or neglect. These exceptions are detailed in our Exception to Privacy, Privileged Communications and Confidentiality Policy below. You will complete a Release of Information form, where you can list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your OPA account.

Children (under age 17) have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians. Due to the charting nature of OPA and the clinical focus of our work with families (not legal), custody issues will not be addressed. Additionally, no court ordered evaluations will be performed.

Initials_____

Exception to Privacy, Privileged Communications and Confidentiality Policy

Any unusual circumstances or information the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else.
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse.
- The client is required to undergo a court-ordered examination.
- The client discloses information about the abuse, neglect or exploitation of a minor, elder or disabled adult.
- The client's mental or emotional condition is used as a legal defense.
- A civil, criminal or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional, in which case the disclosure and release of information shall be limited to that action.

Initials_____

I have received notice of OPA HIPPA Privacy Practices and understand the document fully. Initials_____

Please indicate your agreement to the terms of this policy by signing below: **Date_____**

Printed Patient Name_____

Signature of Patient_____

Printed Name of Responsible Party (if not patient)_____

Signature of Responsible Party_____