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INFORMED CONSENT FOR PSYCHIATRIC TREATMENT and CONFIDENTIALITY

Psychiatric treatment involves a cooperative and collaborative effort between the patient and the psychiatrist whether the treatment involves medication management, psychotherapy or both. Some important issues need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns of yours.

You have contacted me for help with your symptom(s), emotional state, or behavioral problem(s). It is my obligation to offer you the safest and most comprehensive care that I can, to help you to make the change, or gain the relief, that you seek. The treatment you are offered will be tailored to your specific needs. My general philosophy is to avoid medication, and use psychotherapy, behavior, diet, and exercise, etc., whenever possible. However, I do believe that medication (either alone or in combination) can offer relief of burdensome symptoms, often in a more rapid manner than other treatments can.

Psychiatry is both a science and an art. At this stage in the medical understanding of psychiatric symptoms and illness there are few absolutes, and no simple tests to determine needs and specific treatments. Based upon the information you share with me, via the questionnaires and our initial interview, I will provide a diagnostic formulation. This initial assessment often includes more than one possible diagnosis and treatment option.

I encourage your **active involvement and participation** in forming and carrying out your treatment plan. I also ask for your patience as we might not hit upon the most effective treatment with our first plan.

There can be some unintended **negative effects** with any treatment; this includes both therapy and medication. **Psychotherapy** sometimes raises difficult issues or painful memories. **Medications**, prescription or over-the-counter, can cause either mild/non-threatening or serious side effects. It is very important that you ***report any negative symptoms that you are experiencing that you believe might be caused by your medication***.

Many patients, if they're feeling better, feeling worse or simply forget, often discontinue taking their medication. **You should not stop, increase or decrease your medication without discussing it with me.** Symptoms can return with a reduction in dose and certain medications, if stopped abruptly, can cause uncomfortable or serious medical problems. (This doesn't mean that the medications are "addicting" but rather that your body had gotten used to them and is experiencing an abrupt change.) Some medications may have an increased risk of harm if the dosage exceeds the recommended amounts. ***Please keep me informed of any other medications (even non-prescription) or herbal preparations that you are taking*** as there can be problems with drug interactions. All herbal preparations, like other medications, are composed of chemicals and need to be taken with caution.

I encourage you to **discuss any questions and concerns that you have with me**. All treatments, medication or psychotherapy, take time and effort to work.

Attendance: Both you and I are responsible for scheduled appointments. Appointment times will be reserved for you and you alone. You are expected to attend your session and to be on time. If you are late, I may not be able to extend your session. Lateness greater than 20 minutes, without advanced notice (a phone call, text or email, to let me know that you're running late,) may be counted as a missed session. **If you need to cancel an appointment you <u>must call at least 72 hours in advance*</u>. This will allow me time to schedule another patient in your time slot. Failure to cancel with advanced notice will**

count as a missed session. ***You are responsible to pay for missed sessions***. You should be aware that insurance companies can not be billed for and will not pay for missed sessions. *Please discuss your situation with me. If *infrequent*, I might wave my fee for certain unexpected emergencies or illnesses.

Because scheduling frequency is individualized, I have no policy of an absolute limiting number of cancelled sessions allowed per year. However, cancellations can be very disruptive to a patient's treatment plan, and are often difficult for my schedule to accommodate. Excessive cancellations will be reviewed and re-contracted on an individual basis. Unresolved scheduling problems can be cause for termination of treatment and referral to another treatment provider.

I will make every effort to be on time for your session. Rarely, my sessions run late. If so, I will extend your session to the appropriate length of time. If you are unable to extend your session, I will adjust your fee. In rare instances an emergency may arise and I may need to cancel a scheduled session with you with less than 24 hours-notice. In such cases I will make every effort to reschedule your session for a time that is convenient to you.

Fee payment is an important part of the treatment relationship. I am providing a service to you and this is my livelihood. Failure to pay your sessions in a timely manner will affect our relationship and constitutes a breach of our contract. Failure to pay more than two sessions may be cause to terminate the relationship.
--- I understand that your financial situation can change over time and session fees may become difficult to afford. If this is the case, please, discuss this with me and we can consider changed fee, extended payment or other options.

In general I expect payment when my 'service' is rendered*, as well as for late/unexcused cancellations. I do not "accept insurance" and I am not 'In-Network' with any insurance companies, However, I do have software that can electronically submit charges to your insurance company for you to receive reimbursement. If you have insurance please bring your card with you so that I can take an image of it to use. Please also keep me informed of any changes in your insurance so that I can update my software.

I prefer payment with checks or Venmo. They are easiest to track and have no extra fees. I can take a credit/debit card but I may need to add roughly 3% surcharge to cover the processing fees which I am charged by the bank. A Health Savings Account debit card may also incur a fee. To avoid the processing fee, see if your HSA can provide checks for you. (*Keyed-in cards are currently 3.5%, Swiped are 2.5% but this might change*.)

Bounced Checks will also be charged Processing/bank fees.

Medication Renewals: My preference is to handle prescription issues during face to face sessions. I try to include refills to last until our next scheduled visit but sometimes the timing doesn't work out. For patients whom I feel are stable on their current medication regimen I am willing to send in medication renewals a couple of times per year.

NYS mandates electronic prescribing of all medications. If you send me a request please confirm the name/address (& zip code) of your pharmacy, your exact medication and dose.

If you are running low on your medications plan ahead! Contact me with at least several days or a week advanced notice. I may need to speak with you and **I might not be available on the day you run out of your medication.**

Although time constraints, traveling and payment for sessions can be difficult for some people I have a *minimum* requirement of an evaluation session every 3 - 4 months for patients I consider 'active' in my

practice. Also, be aware that non-routine medication renewal is a billable service that takes time and effort from me. Please discuss potential fees with me.

EMERGENCIES: Emergencies may arise during our work together. I am reachable by cellular telephone, but there is always a limit to that form of communication (dead spots, phone temporarily off, noise, etc.) If you have tried to call and I do not get back to you in a reasonable period of time, please try again and TEXT to alert me to a missed call or message that my phone my not have registered.

If your issue is urgent, or if you are having, or suspect you are having a reaction to or problem with your medication CALL me! I would rather we have an extra call or two than not have you call with an important concern. If you can't reach me you should go to your nearest emergency room. Of note: it is good practice to have all of your mediations, medical conditions, doctors, their contact numbers, and allergies listed on a paper kept in your wallet or in your phone.

Other Communication: Please refrain from after-hours (late night or week-ends) contact for routine issues such as scheduling, medication refills, or any other issues that can be addressed during usual Monday-Friday work hours.

Email Communication can be used to facilitate our work together. Not all email is secure and I cannot promise the safety or confidentiality of any information sent or received. Email is best used when you need to address *brief* issues you need me to attend to and respond to. Email should not be used for emergencies or other urgent communications. (**If it's urgent, call! If I don't answer, leave a message.)** Please note, it is not my practice to handle medication and symptom management via email, but you can/should always ask a quick question or request a clarification after a session.

Texting should only be used for brief, non-emergent communication, such as "I'm running late." And to let me know you've 'arrived.'

FEDERALLY MANDATED HIPAA CONTENT TAKEN FROM THE INTERNET:
In general, the **confidentiality** of all communications between a patient and psychiatrist is protected by law. I can only release information about our work together with your permission. However, there are a few exceptions:

In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some **circumstances when I am required to breach confidentiality without a patient's permission**. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm himself or herself, I may be required to contact family members, the police or seek hospitalization.

The clear intent of these requirements is that a psychiatrist has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists. Fortunately, these situations rarely arise in my practice.

There are several **other matters concerning confidentiality:**

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee. Patients will be charged an appropriate fee for preparation.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary. If you request it, I will provide you with a copy of any report which I submit.

4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment.

5. Under current New York State law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex and I am not an attorney. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable State laws governing these issues.

INFORMED CONSENT FOR PSYCHIATRIC TREATMENT and CONFIDENTIALITY

I have received a copy of Dr. Elizabeth Getter's **Informed Consent and Confidentiality Policies**.

I have read the Informed Consent and Confidentiality Policies and fully understand the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached.

I understand my diagnosis, and the nature of my proposed treatment, including my responsibility to the treatment, as well as alternatives to this treatment:

I have discussed with Dr. Getter her evaluation and diagnostic formulation of my symptoms. The nature of the treatment proposed for me has been described, including possible side effects, as well as the pros and cons of this and alternative forms of treatment. I am aware that starting, stopping or reducing the dosage of medications without medical guidance may run the risk of adverse effects (side effects.) I agree not make changes to my medication regimen (including taking medications from other physicians) without discussing these changes with Dr. Getter.

I authorize Elizabeth V. Getter, MD to obtain my past two years of prescribed medication history.

I am aware that I should contact Dr. Getter with any questions or concerns I have regarding my diagnosis and/or treatment.

I understand and agree to abide by Dr. Getter's scheduling policies and policies regarding payment, missed appointments, matters relating to insurance, and if applicable, preauthorization and utilization review issues:

I have discussed my session fees with Dr. Getter.

I am responsible for payment of all fees to be charged.

I understand that 'bounced checks' will incur a fee.

I understand that I must call to cancel any appointments at least 72 hours in advance. I will be charged for missed appointments including appointments cancelled less than 72 hours in advance*. I am aware that my authorized credit/debit card may be billed for these appointments.

I am aware that my authorized credit/debit card may be billed to pay for services rendered according to our fee agreement, if I have not otherwise paid those fees in a timely manner.

I am aware that outstanding invoices over 30 days old may accrue interest charges and that I am responsible to pay those charges.

If I fall more than two payments behind, unless otherwise agreed to, my care with Dr. Getter may be terminated and transferred to another provider or suitable clinic.

I understand I may withdraw from any aspect of my treatment plan at any time but if I decide to do this I will discuss my plan with Dr. Getter before acting on it.

__________________________________ ____________________
Signature Date

____
Print Name

PAYMENT AGREEMENT/AUTHORIZATION - SIGNATURE ON FILE – RELEASE OF INFORMATION

Patient's name: Date:
Financially responsible party:

I understand that I am financially responsible for all charges (as outlined in the informed consent agreement) whether or not paid by insurance. I authorize Elizabeth V. Getter, MD, PLLC to bill any outstanding charges the credit card below.

Credit Card: ☐ AmEx ☐ MasterCard ☐ Visa ☐ Discover	Card#:
Name as it appears on card:	Expiration date:
Billing address:	CVV:
	Email:

Signature *of Card holder/Financially responsible party* *Date*

INSURANCE ISSUES

If a person, other than you [the patient] is the name on the insurance policy you'll be using, please fill out their information below.

INSURED'S	Name:		Relation to pt.:
Address:			
City:		State	Zip -
DOB: / /	Phone ( ) - **EMAIL:**		

☐ I do not have insurance or decline use of my insurance.

☐ I certify that I, and/or the above named insured have active insurance coverage with:

Insurance Co:	Policy number:
Group name:	Group number:

☐ I authorize Elizabeth V. Getter, MD [EVG] to act as my agent in helping me obtain payment from my insurance company(s).
☐ I authorize Dr. Getter to use my name on any claims or documents that relate to health insurance benefits due to me and my dependents.
☐ I authorize Dr. Getter to submit my claims to my insurance electronically through the use of the Billing Intermediary, 'Trizetto Gateway EDI' I
☐ permit the use of a copy of this authorization to be used in place of the original signature on all insurance submissions.
☐ I hereby authorize and give my consent to Elizabeth V. Getter, MD to discuss the any confidential and private health information related to any claims, such as: psychiatric, substance use and medical history, diagnoses and treatment with my insurance company in order to facilitate the payment for my mental health care.
☐ Initial ________ MEDICARE patients: I request that payment of my insurance benefits be made on my behalf directly to E.V.Getter,MD

I understand that I am not required to give these *insurance related consents* and that if I refuse I will be offered psychiatric services but the potential effect upon the payment of my mental health care will be discussed with me.

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken; it shall be effective only long enough to answer the purpose for which it is given, and no further confidential information will be released without the execution of an additional written statement of my consent.

Signature *of Patient, Guardian or Personal Representative* *Date*

Signature *of Insurance policy holder/Beneficiary* *Date*