MENTAL HEALTH SOLUTIONS S.C.

OUTPATIENT SERVICES – PSYCHIATRIC CARE CONTRACT

Name of Client:_____ Prescriber:_____

Following an initial assessment of needs, it has been determined that I am an appropriate candidate for receiving psychiatric services through this clinic. My prescriber has provided written and/or verbal information concerning my rights as a patient including:

Treatment

Treatment recommendations and proposed benefits, treatment alternatives, possible outcomes and side effects of treatment, possible outcomes of no treatment, and the approximate duration of treatment have been discussed. I have the right and responsibility to participate in the development and implementation of my treatment plan.

Patient Rights

My rights as a patient have been explained. This includes information on how to obtain emergency mental health services outside of the clinic's normal operating hours, how to use the clinic's grievance procedure, and the discharge policy of the clinic including circumstances under which a patient may be involuntarily discharged for inability to pay or for behavior that may be the result of mental health symptoms. These items are detailed in a separate document offered to me entitled *Consumer Rights of Individuals Receiving Treatment at Mental Health Solutions, S.C.*

Medications

If medications are prescribed I will sign a separate consent that indicates that the prescriber has explained to me or to my legal representative the risks, benefits, and alternatives to medication treatment.

Fees

The fee for services is based on the complexity of care provided. Initial consultation services are complex and are billed at $300. Standard medication follow-up sessions vary in length from 20 – 30 minutes and range in cost from $150 to $390. Longer sessions including additional therapy and evaluation incur additional fees.

Missed appointments prevent me from receiving required care and prevent the prescriber from providing that care. They also prevent another person from receiving care during that time. As a result, I will be financially responsible for any missed appointments or appointments not cancelled with at least 24 hours notice (emergency exceptions may apply). The fees for late cancellations are assessed on an escalating fee scale. The first late cancellation will not be charged, the second late cancellation will be charged at $50, the third late cancellation will be charged at $75, and the fourth and subsequent late cancellations will be charged at $100 and my care may be terminated. The fees for missed appointments are also assessed on an escalating fee scale. The first missed appointment will be charged at $50, the second missed appointment will be charged at $75, the third and subsequent missed appointments will be charged at $100 and my care may be terminated. My insurance will not cover fees for missed appointments.

I understand it is important to arrive on time for appointments. If I am too late to allow time for proper care, I may be asked to reschedule. If I am more than 20 minutes late, I will be asked to reschedule.

It is Mental Health Solutions' policy to charge on a prorated basis for other professional services such as extended telephone consultations, report writing, meeting attendance, court testimony, and preparation of treatment summaries. I am responsible for any charges not covered by my insurance carrier including any co-payments required by my policy. Co-payments are a contract between me and my insurance company and cannot be waived. Unpaid balances will be referred to collections and may result in termination of my care.

My signature below indicates that I:

1) Have been informed of my consumer rights
2) Have been advised that a copy of this clinic's consumer rights and grievance procedure is available at the front desk
3) Have read and understood my consumer rights and this outpatient services agreement
4) Have authorized Mental Health Solutions, S.C. to access my medication history online
5) Have authorized Mental Health Solutions, S.C. to release information to my insurance company as necessary for processing claims
6) Have authorized direct payment from my insurance carrier to Mental Health Solutions, S.C.
7) Understand that I can withdraw from this agreement and/or stop treatment at any time.

Signature of Client (14 and older):_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

Signature of Witness:_____ Date:_____

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