Freedom Psychiatry Services
7540 Ramble Way, Suite 109, Raleigh NC 27616
Question? Call: (919) 457-1200

Acknowledgement of Receipt

By initialing below, I acknowledge that I have received a copy of the following policies for Freedom Psychiatry Services, PLLC. I understand that I may request a full copy of any policy at any time.

_____ ATTENDANCE, CANCELLATION, AND NO-SHOW POLICY

_____ AUTHORIZATION TO BILL INSURANCE AND PAYMENT AGREEMENT

_____ SELF-PAY POLICY

_____ INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

_____ PRIVACY NOTICE

_____ AUTHORIZATION FOR THE RELEASE OF PROTECTED INFORMATION

_____ REASON FOR DISMISSAL POLICY

ACKNOWLEDGEMENT

By signing below, I confirm that I have read, understand, and agree to the policies outlined by Freedom Psychiatry Services, PLLC. I acknowledge that it is my responsibility to adhere to these policies and that I may request clarification if needed.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Appointment Attendance, Cancellation, and No-Show Policy

At Freedom Psychiatry Services, PLLC, we are committed to providing exceptional and high-quality care. Consistent follow-up visits are essential for effective treatment and patient well-being. Missed appointments and late cancellations disrupt care continuity, impact other patients who may need appointments, and create unnecessary costs for the practice.

When you schedule an appointment, that time is reserved exclusively for you. If you are unable to keep your appointment, please notify us in advance to reschedule or cancel in accordance with our policy.

Cancellation & No-Show Policy

1. **First Missed Appointment (No-Show):**
   - The patient will receive a courtesy phone call or message as a reminder of our policy.
2. **Second Missed Appointment (No-Show):**
   - The patient may be subject to discharge from the practice at the practice's discretion.
3. **No-Show Fees:**
   - All no-show appointments are subject to a $50.00 no-show fee.
   - To avoid this fee, patients must provide at least 24 hours' notice when canceling an appointment.
4. **Late Cancellations:**
   - Appointments canceled less than 24 hours before the scheduled time are considered a no-show and will be charged a $50.00 fee.
5. **Late Arrivals:**
   - Patients should arrive at least 15 minutes prior to their scheduled appointment to allow time for check-in.
   - If a patient arrives more than 10 minutes late, they may be asked to reschedule and will be charged a $50.00 late fee.
6. **Emergency Exceptions:**
   - We understand that emergencies can arise, and we will review late cancellations and no-shows on a case-by-case basis.
7. **Credit Card on File Requirement:**
   - All patients are required to keep a valid credit card on file for the collection of any associated fees, including no-show, late cancellation, and late arrival fees

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Self-Pay Policy

At Freedom Psychiatry Services, PLLC, we are committed to providing high-quality care to all patients, including those who:

- Do not have health insurance,
- Have an insurance plan that is out of network, or
- Elect not to use their insurance for services.

For patients choosing to self-pay, the following policies apply:

Self-Pay Rates

- Initial Psychiatric Evaluation (Intake Appointment): $285.00
- Follow-Up Appointments: $190.00 per session
- Completion of Family Medical Leave/Short-Term Disability forms: $55.00

Payment Terms & Requirements

1. **Payment Due at Time of Service:**
   - All self-pay patients are required to pay in full at the time of each appointment.
   - Payment can be made via credit card, debit card, HSA/FSA card, or cash.

2. **Credit Card on File Requirement:**
   - Patients must have a valid credit card on file for any outstanding balances or missed appointment fees (see Attendance, Cancellation, and No-Show Policy).

3. **No Insurance Claims Submitted:**
   - Patients who self-pay acknowledge that Freedom Psychiatry Services, PLLC will not submit claims to insurance or provide billing for reimbursement.
   - Upon request, we can provide a superbill for patients who wish to seek reimbursement from their insurance provider.

4. **Refunds & Outstanding Balances:**
   - Payments are non-refundable once services have been provided.
   - Patients with outstanding balances must resolve their balance prior to scheduling future appointments.

No-Show and Late Cancellation Fees

- Missed Appointments / No-Show Fee: $50.00
- Late Cancellation Fee (Less than 24 hours' notice): $50.00
- Late Arrivals Fee (Arriving 10 Minutes+ Late): $50.00
- Fees will be automatically charged to the credit card on file.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Reason for Dismissal Policy

At Freedom Psychiatry Services, PLLC, our goal is to provide high-quality, patient-centered care in a respectful and professional environment. However, there are circumstances under which a provider may ethically and legally terminate a patient-provider relationship. The American Medical Association (AMA) Code of Ethics and state regulations outline appropriate reasons for dismissal, which include but are not limited to:

Reasons for Dismissal

1. **Non-Compliance with Treatment:**
   - When a patient fails to follow the treatment plan recommended by their provider, it hinders their progress and the ability to provide effective care. Collaboration between patient and provider is essential for achieving the best outcomes.

2. **Repeated Missed or Canceled Appointments:**
   - Frequent last-minute cancellations or failure to attend scheduled appointments disrupts care continuity and limits access for other patients in need.
   - Patients who do not show up for appointments without prior notice (No-Call/No-Show) will be subject to a $50.00 No-Show Fee.

3. **Disruptive or Inappropriate Behavior:**
   - Any rude, aggressive, or inappropriate behavior toward staff, providers, or other patients will not be tolerated. Respectful communication is required in all interactions.

4. **Failure to Pay Outstanding Balances:**
   - Patients are responsible for timely payment of co-pays, deductibles, and outstanding balances. Repeated non-payment may result in dismissal.

5. **Medical Needs Beyond Our Scope of Care:**
   - If a patient's medical or psychiatric needs exceed the services we can provide, we may recommend referral to a specialist or another healthcare provider who can better meet their needs.

6. **Practice Closure or Provider Departure:**
   - If Freedom Psychiatry Services, PLLC closes or a provider leaves the practice, we will make every effort to facilitate a smooth transition of care.

Dismissal Process

- If a patient is dismissed from the practice, they will receive a written notice explaining the reason for dismissal.
- The provider will authorize a 30-day supply of necessary medications to allow time for the patient to establish care with another provider.
- Patients will be responsible for finding a new provider and transferring their medical records.

Our practice continues to grow, and we are committed to maintaining a professional, respectful, and effective treatment environment. We appreciate your cooperation and understanding in upholding these policies.
Thank you for choosing Freedom Psychiatry Services, PLLC for your care.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Informed Consent For Assessment And Treatment

Introduction

I understand that I am eligible to receive a range of behavioral health services from my provider at Freedom Psychiatry Services, PLLC. The type and extent of services I receive will be determined based on an initial assessment and a collaborative discussion with my provider. The goal of this assessment is to determine the most appropriate and effective course of treatment for me. Treatment typically occurs over multiple sessions and is tailored to my individual needs.
Patient Rights & Responsibilities

I acknowledge that:

- I have the right to ask questions at any time during the course of treatment.
- I may seek a second opinion or outside consultation if desired.
- My provider may provide me with additional information about specific treatment methods and I have the right to consent to or refuse such treatment.
- My treatment plan will be reviewed regularly to assess progress and determine if adjustments are necessary.
- I agree to be actively involved in my treatment and the review process.
- No guarantees have been made regarding the outcome of treatment or any procedures utilized.
- I have the right to discontinue treatment at any time, but I agree to discuss this decision with my provider before doing so.

Confidentiality and Limits of Privacy

I understand that my treatment records are confidential and will not be disclosed without my written authorization, except in the following situations where my provider is legally required or permitted to breach confidentiality:

1. **Risk of Harm to Self or Others:**
   - If my provider believes I am at imminent risk of harming myself or another person, they may seek emergency intervention, including hospitalization.
2. **Suspected Abuse or Neglect:**
   - If there is reason to suspect that a child, elderly person, or vulnerable adult is being abused, neglected, or is at risk of such harm, my provider is legally obligated to report this to the appropriate authorities.
3. **Court Orders & Legal Proceedings:**
   - If my medical records are legally subpoenaed or a valid court order is issued, my provider may be required to release the requested information.
4. **Insurance & Third-Party Disclosures:**
   - If I choose to use insurance benefits, I understand that certain information may be shared with my insurance provider for claims processing and authorization of services.
   - Once information is disclosed to an insurance company or other third party, Freedom Psychiatry Services, PLLC cannot guarantee its confidentiality.

For a more detailed explanation of my privacy rights, I understand that I should refer to the Privacy Notice, which has been provided to me. I am encouraged to discuss any concerns regarding confidentiality with my provider.

Acknowledgment

- I voluntarily consent to behavioral health evaluation, treatment, and services as recommended by my provider.
- I understand that behavioral health treatment is not an exact science, and no guarantees have been made regarding treatment outcomes.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Authorization to Bill Insurance and Payment Agreement

I certify that I have sought evaluation, treatment, or medical advice from the providers at Freedom Psychiatry Services, PLLC. I authorize the medical staff and personnel to release my (or my minor child's) medical information to my insurance company for the purpose of determining eligibility and processing claims for medical services rendered.

I understand that Freedom Psychiatry Services, PLLC will submit insurance claims on my behalf as a courtesy; however, I acknowledge that I am financially responsible for any portion of my medical expenses that are not covered by my insurance policy. This includes, but is not limited to:

- Deductibles
- Co-payments
- Co-insurance payments
- Any non-covered services

If my account balance exceeds $200, I understand that a payment arrangement will be required. I agree to make timely payments in accordance with any agreed-upon plan.

I further acknowledge that any unpaid balances will be billed to me at the address I have provided. Failure to make timely payments may result in denial of services and/or referral to a collections agency or legal action

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Privacy Notice

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Privacy Notice apply to the medical practice of Freedom Psychiatry Services, PLLC (hereinafter referred to as "Freedom Psychiatry"). We are committed to protecting the privacy and confidentiality of your Protected Health Information (PHI) in compliance with applicable laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA).

Use and Disclosure of Your PHI

While providing evaluation and treatment, Freedom Psychiatry may obtain PHI from you and other medical or non-medical sources. With your signed Treatment Consent, we may use and disclose the minimum necessary PHI for purposes of Treatment, Payment, and Healthcare Operations (TPO) as follows:

- **Treatment:** Sharing information with healthcare providers, specialists, relatives, or friends involved in your care, arranging hospitalizations, placing diagnoses on laboratory or imaging order forms, telephoning prescriptions, and providing insurance-related information for prescription coverage.
- **Payment:** Submitting insurance claims to third-party payers (e.g., Blue Cross Blue Shield), communicating with utilization review professionals for service authorization, and working with collection agencies if necessary.
- **Healthcare Operations:** Quality assurance activities, case management, compliance audits, and appointment reminders (via voicemail, email, or text).

We do not disclose patient information for marketing purposes without your explicit written consent.

Disclosures Required or Permitted by Law

Certain circumstances require us to disclose your PHI without your consent as mandated or permitted by law, including but not limited to:

- **Government Oversight:** Upon request by the Department of Health and Human Services (HHS) for regulatory compliance.
- **Public Health & Safety:** Reporting suspected child or elder abuse, domestic violence, infectious diseases, injuries, or deaths to appropriate state or local agencies.
- **Product Safety:** Reporting adverse drug reactions or product recalls to the Food and Drug Administration (FDA).
- **Legal Proceedings:** Disclosing information if your mental health becomes a subject of legal inquiry.
- **Threats to Safety:** If our providers determine that you pose an imminent danger to yourself or others, we must notify appropriate parties to prevent harm.

Other Uses & Disclosures Requiring Your Authorization

Any other use or disclosure of PHI will require your written authorization, which you may revoke at any time in writing, except where we have already acted in reliance on it.

Your Rights Regarding Your PHI

You have the following rights concerning your PHI:

1. **Confidential Communications:** You have the right to request alternative means of receiving PHI (e.g., different mailing addresses, email preferences).

2. **Access to PHI:** You have the right to inspect and obtain copies of your PHI, except for psychotherapy notes, records compiled for legal proceedings, or information obtained under a promise of confidentiality.

3. **Requesting Amendments:** You may request, in writing and with supporting reasons, that we amend your PHI. While we may approve or deny the request, you have the right to submit a written statement of
   disagreement, which we will document in your records.

4. **Accounting of Disclosures:** You may request a list of disclosures made after April 14, 2003, excluding those related to treatment, payment, healthcare operations, or those authorized by you.

5. **Restrictions on Use & Disclosure:** You may request restrictions on the use or disclosure of your PHI. While we are not required to agree, we may refuse treatment if we cannot accommodate your request.

Our Responsibilities

Freedom Psychiatry Services, PLLC is required by law to:

- Maintain the privacy and security of your PHI.
- Provide this Privacy Notice detailing our legal obligations and privacy practices.
- Abide by the terms of this Privacy Notice currently in effect.
- Notify you in the event of a breach that may have compromised the security of your PHI.

We reserve the right to update this Privacy Notice. Any revisions will apply to all PHI we maintain and will be posted in our office and available upon request.

Complaints and Contact Information

If you believe your privacy rights have been violated, you may file a written complaint with:

Freedom Psychiatry Services, PLLC
Attn: Dr. Kondal Madaram
7540 Ramble Way, Suite 109
Raleigh, NC 27616
Phone: 1-919-457-1200

You may also submit a complaint to:

U.S. Department of Health & Human Services
Office for Civil Rights
200 Independence Avenue, SW
Washington, D.C. 20201
Phone: 1-877-696-6775

Filing a complaint will not result in retaliation.

☐ I agree to use electronic signature.

Please type your name to sign below: Date:

PCP Financial Agreement

I understand that payment for any service not covered or denied by my insurance company (co-payment/insurance, deductible, pre-existing condition, failure to obtain a prior authorization/referral, etc.) will be my responsibility. I also understand that my insurance plan may not cover certain preventive charges as spirometry, urinalysis, pulse 02 and stool hemoccult testing and therefore authorize my physician to bill these charges to me instead of my insurance company.
Patients who have HMO Policies are required to select a Primary Care Provider (PCP) before being treated. I understand that if I have an HMO policy and have not selected the rendering physician as my primary care physician, I am waiving my insurance benefits and will be responsible for payment.

☐ I agree to use electronic signature.

Please type your name to sign below: Date:

Consent for Diagnosis & Treatment

I acknowledge that I am voluntarily giving my permission to the authorities of Freedom Psychiatry Services PLLC and the Provider in charge, as they may deem necessary, to provide Mental Health services to me.

This will include discussion of tentative diagnosis, methods and modalities to be used in treatment and possible outcomes. I understand that as a part of this process, I may be recommended to receive diagnostic testing, psychological testing, psychotherapy and/or medication management. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be painful and difficult. I understand that I have the ability to decline the aforementioned services at any time, but this may affect my treatment process and outcome.

I understand that the clinic does not provide 24 hours coverage for my medical/psychiatric need. In case of an urgent or life-threatening situation, I would either call 911 or go to the nearest emergency room.

Any patient seeing the Nurse Practitioner, could be discussed with and supervised by supervisor. If applicable, I agree to practice contraceptive measures while taking any psychotropic medications as they can be harmful to an unborn baby. I will notify my physician in advance before a planned pregnancy.

I also understand that refusal to comply with the Provider's recommendations could result in grounds for termination of the patient-physician relationship. I also understand that I have the right to terminate the relationship at any time.

I further acknowledge that I have read and understand the Policies and Procedures, and that I understand the limits of confidentiality regarding treatment, and the office policies regarding scheduling, emergency coverage, fees and billing, insurance filing, missed appointments, court appearances, copying records, prescription refills, phone consultations, etc. I acknowledge my understanding of and my willingness to abide by these policies and procedures by my signature below.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Confidential Exchange of Healthcare Information

Health Practitioner / Provider: Name: Freedom Psychiatry Services PLLC
Phone: (919) 457-1200 Fax: (919) 457-1100
Address: 7540 Ramble Way, Ste 109, Raleigh, NC 27616

I, at this moment, voluntarily, freely, and without coercion authorize the Freedom Psychiatry Services PLLC Practitioner listed above to release pertinent information to my primary care (PCP) & other providers in my care team. This release of information is to assist in the continuity and coordination of my treatment. This consent will automatically last one year from the date signed. I understand that I may reverse my consent at any time.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Assignment of Benefits

I certify the accuracy of the patient and insurance information provided above and hereby assign to Freedom Psychiatry Services PLLC (FPS) any insurance (commercial or government) and/or third-party benefits available for healthcare services provided to me.

I authorize the use of this signature on all my insurance submissions whether electronic or manual.

I understand that FPS has the right to refuse or accept assignment of such benefits.

If these benefits are not assigned to FPS, I agree to forward to FPS all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I understand that my healthcare benefits may assign a portion of the bill to me and agree to pay any balance not covered (co-payment, co-insurance, insurance deductible, pre-existing condition, failure to obtain a referral/prior authorization, etc). Any unpaid balances may be turned over to a third party for collections and the patient (or patient's legal guardian) will be responsible for all collection charges (15% of outstanding balance), in addition to, interest (6% of outstanding balance). attorney and/or court costs.

☐ I agree to use electronic signature.

Please type your name to sign below:

Date:

Patient Record of Disclosures

Questions

Personal Representative of Patient:

I hereby give permission to the person(s) listed below to authorize treatment, attend office visits, and to receive information about the care of the above-named patient. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (PHI), prescription pick up, and the ability to set appointments. (If not listing more than one, please write 'N/A' for the other lines listed)

1) Name:

Write here...

2) Relationship:

Write here...

3) Phone number:

Write here...

By accepting this service and signing below, you are giving Freedom Psychiatry Services permission to give you a reminder call, text, and/or email, including permission to leave a message on your answering machine/voice mail, or with anyone who might answer your telephone. If you do not wish to receive this courtesy service, please select the "decline" option below.

◉ ACCEPT: "I would like to receive reminder calls, texts and/or emails and give permission to Freedom Psychiatry Services to leave a message for me if I am unavailable."

○ DECLINE: "I would NOT like to receive reminder calls, texts and/or emails and do NOT give permission to Freedom Psychiatry Services to leave a message for me if am unavailable."

☐ **I agree to use electronic signature.**

Please type your name to sign below:

Write here...

Date: