FROM THE OFFICE OF MARC H. REINER, M.D.
DIPLOMATE: AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

# Bay View Psychiatry

## *POLICY STATEMENT*

The following sets for the terms and conditions upon which our services are rendered.

***Consent of Treatment, Payment, and Health Care Operations***
I hereby consent to the use or disclosure of my protected health information by Bay View Psychiatry for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. *I understand that diagnosis and treatment of me is conditioned upon my consent as evidenced by my signature of this document.*

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or health care operations of this medical practice. Bay View Psychiatry is not required to agree to the restrictions that I may request. However, if this office agrees to any restriction that I request, then this restriction is binding. I have the right to revoke this consent at any time, in writing, except to the extent that Bay View Psychiatry has taken action in reliance to this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by this provider, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical health, mental health and condition, and identifies me, or gives reasonable basis to believe information may identify me.

I understand I have a right to review Bay View Psychiatry's *Notice of Privacy Practices*, and that a copy is available upon my written or verbal request.

The *Notice of Privacy Practices* describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations. This *Notice of Privacy Practices* also describes my rights and the duties with respect to my protected health information. I understand this medical office reserves the right to change the privacy practices that are described in the *Notice of Privacy Practices*. I may obtain a revised *Notice of Privacy Practices* by requesting it in writing, either by mail or at my next appointment, and a revised copy will be sent in the mail or provided to me in person at next appointment.

***Confidentiality***
Professional ethics and California state law specifies that communications to medical staff are confidential and privileged, and cannot be released or shared without the express written permission of the patient, except as noted above. However, there exist a few instances that are mandated by law to report certain information. These include, but are not limited to, abuse of minor, or if you express the intent of bringing harm upon yourself or another person. In such circumstances, the provider is required to inform potential victim(s) and legal authorities.

***Payment of Fees***
Payment of services is the responsibility of the patient, or in the case of the patient being a minor, responsibility of the parent/guardian. As evidenced by signature, I agree to pay my share of the charges, such as co-payment and deductible amounts, at the time of each visit. The charge for each appointment depends upon the time I spend with the physician, and the type of visit for which I am seen. I understand that the fees imposed by Bay View Psychiatry are within the usual and customary rates for medical services in the San Diego area. For specific dollar amounts, please ask the office staff. Please note that this office charges a $50 service fee for all returned checks.

***Insurance***
This office will submit your insurance claims to your carrier, at no cost to you. However, we are not in a position to guarantee payment from your insurance company since the claim is based upon arrangements between you and the insurer. Please be aware that it is common for insurance companies to subcontract certain benefits to another company. In these instances, we may not bill your insurance company; we may be required to bill your medical group or a third party payer. I understand it is my responsibility to know if this is true.

***Prior Authorization***
Prior authorization may be required before your first visit. Please be aware that it is your responsibility to know if this is true for your insurance coverage(s), and to get the necessary authorization(s).

***Appointments***
Your appointment time has been reserved exclusively for you. I agree that if I fail to cancel my appointment with at least 24 hours advance notice, I will be billed a $100 missed appointment fee, and that insurance companies do not cover missed appointment fees.

***Medical Records***
I understand that Bay View Psychiatry will retain my medical records for seven years as per legal requirements. Copies of records can be transferred to other health care providers upon receipt of a valid written consent. I understand that this office requires at least 72 hours notice prior to medical records being made available to authorized party.

***Medications***
I understand that all medication will be prescribed by Dr. Marc H. Reiner only and that all medication refills will be considered during office hours only. This is so the office can conform with California pharmacy statutes, and to prevent the possibility of other persons from acting or posing as patients of Marc H. Reiner, M.D., or obtaining medication illegally. I further understand that if I should need to have a prescription refilled that I should contact my pharmacy at least 1-2 days prior to needing the medication or the medication may not be available the same day. I understand refills for my prescriptions will not be performed unless I have been seen within the last six months, extenuating circumstances notwithstanding.

***Agreements***
I have reviewed the preceding information and I certify that this information is accurate. I further understand that I am responsible for any financial loss due to incomplete or inaccurate information provided by me. I hereby authorize payment directly to this medical provider any insurance benefits that would otherwise be payable to me for services rendered. In instances where insurance does not pay any benefits, I agree to pay for those services. If payment is not received within 90 days from the date the claim was submitted, I agree that I will become responsible for the full amount of the balance on my account.

Should I break the financial arrangements as detailed above, I agree that my name may be released for collection purposes. I understand that no treatment related information will accompany this disclosure. I also agree that if any legal action is taken to enforce the provisions of this *Policy Statement* that the prevailing party shall be entitled to reasonable attorney's fees and costs.

***I have read this Policy Statement and agree to the terms as stated:***

_____
Patient's Name (Print)

_____ _____
Patient (or Parent/Guardian) Signature Date