

Consent to Treatment

Welcome to Southeast Psychiatry. It is my intention to provide the highest quality of mental health services in a comfortable, safe and secure environment. To that end, I wish to outline some of the basic guidelines of my practice and request that you acknowledge your understanding of them. If you have any questions about the services I provide or the terms of their provision please discuss them with me before we initiate the treatment process.

Philosophy of treatment:

I believe that the goal of obtaining substantial and durable improvements in an individual's mental health is best achieved by combining the most effective elements of psychotherapy with the careful use of psychiatric medications. While some of my efforts will be directed to symptomatic relief I will always strive to help you initiate durable changes in your understanding of and the responses you have to the conditions bringing you in to treatment. At the most fundamental, my practice is about sharing my training and experience with you to help you progress in your journey through life.

What you can expect from me:

I will provide professional, respectful, and evidence based psychiatric care for any conditions that can be appropriately treated in an office environment. I will maintain strict confidentiality of our work together in accordance with the terms set forth regarding confidentiality in this agreement. I will advise you as to the risks, benefits, and alternatives of any proposed treatments.

Confidentiality:

I will not share the existence and content of our therapeutic work with others. There are two exceptions to this rule. The first is in the case of imminent potential harm to you or to others. The second is when you have provided me with documented consent to share information with others. Examples of this would include submission of basic information to insurers and communication with your other health care providers.

Initial that you have read the entire page
& understand _____

What is expected of you:

I expect you to keep your appointments with me. If you are unable to do so I ask that you provide notification of that at least 24 hours in advance with the exception of unforeseen emergencies.

There is a \$50 no show fee, in the event that you do not give proper advance notice for a missed appointment. We will take into consideration emergency circumstances. Waiving the fee will require a note and notification from me stating the reason for the exception.

It is your responsibility to inform our office immediately, of any phone, mailing address, email, or insurance changes. Without this updated information you may be responsible for full payment of or loss of appointments.

Medication refill requests may take up to 48 hours to process. It is important to let our office or your pharmacy know a few days in advance of running out on your medication.

You will actively participate in your treatment and follow directions regarding medication to the best of your ability. The security of your medications is your responsibility – please treat them with respect for the safety of yourself and others. I expect you to communicate honestly with me about your progress in the treatment process.

Fees for services provided:

- Initial Psychiatric evaluation, 1 hour: \$275.00 (most common)
- Follow up psychotherapy, 45 minutes: \$200.00
- Follow up psychotherapy with medication management, 45 minutes: \$230.00
- Follow up psychotherapy with medication review, 30 minutes: \$180.00
- Medication review and management, 15 minutes \$110.00

Peripheral services (phone calls, letters, reports, family meetings etc.) in excess of 10 minutes will be billed in quarterly fractions of an hourly rate at \$250.00

We do not file forms, applications, certifications, or complete assessments in regards to certifying disability status.

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Insurance:

At your request fees will be submitted to your insurer and I will forward bills for unpaid remainders to you. If I have a contract with your provider I will follow the procedures dictated by that insurer. Ultimate responsibility for payment of fees remains with you.

A monthly statement will be mailed to you. You are expected to remain current in payment for the fees you are charged for the services I provide. Account balance in excess of \$300, may result in suspension of services until a payment plan is in place or the balance is paid in full.

Court testimony:

We do not willingly provide court testimony, as it violates confidentiality and damages the therapeutic relationship. In the event of subpoena it is the patient's responsibility to issue a motion to quash it. Failing that we will charge \$200 to issue our own. Should I find myself in court anyway I will charge \$500 per hour spent plus any legal fees incurred in the protection of confidential information. These fees will be billed to the patient, as they are not covered by insurance.

In case of emergency:

For urgent questions and concerns, including unexpected side effects from medications or worsening of your condition, please call the office number and leave a message. I check my messages daily and will respond in most cases within 24 hours. Should you feel at risk for immediate harm or in need of urgent medical treatment please seek out care at the nearest emergency department. In the event of this situation, please also leave a message with me so I can promptly assist in the coordination of your care. If I am unable to respond to messages within 24 hours I will leave this information and directions on how to proceed in the interim on my answering service.

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& understand _____

**Welcome to Southeast Psychiatry and thank you for
entrusting me with your care.**

Paul Topol M.D.

**I have read the entire consent for treatment and agree to the treatment as
described.**

Patient Name: _____

Signature: _____

Date: _____