MED PSYCH SERVICES
Keeping You Healthy and Happy

# PATIENT POLICES

## Read entire document before signing

**Scheduled Appointments:**

The patient appointment will be prioritized according to the scheduled time. We will make a reasonable attempt to accommodate the patient if they show up late. Please inform us as soon as possible if you are running late. However, if the patient is 15 minutes past the scheduled time, he/she may need to be rescheduled.

**Appointment Cancellations/No Show:**

Failing to keep appointments or cancelling without notice may subject you to discharge from the practice. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you don't call to cancel the appointment, you may be preventing another patient from getting much needed treatment. EXCEPTIONS will be dealt with on a case-by-case basis and are at the discretion of the practice. Practice will adhere to the following procedures:

- If the appointment is cancelled with at least 48 hours' notice, the client will not be penalized.
- A first-time cancellation within fewer than 48 hours of the scheduled appointment will not be penalized.
- A second and any further cancellation within fewer than 48 hours of the scheduled appointment will result in a fee of $50.00. *Your insurance company will not reimburse you for missed appointment/late notice fees.*
- A third or greater cancelation/no show you may be discharged from the clinic.

**Payments and Account Balances:**

- Payment for services including co-payments are due at the beginning of the service. Major credit cards, personal checks, and cash are accepted.
- We will require that patients with self-pay balance do pay their account balances to zero, prior to receiving further services by our practice.
- A $25 fee is charged for all returned checks.
- Patients who have questions about their bills or who would like to discuss a payment plan may call and ask to speak to a business office representative with whom they can review their account and concerns.
- Unless arrangements are made for a payment plan, all accounts that are outstanding for **greater than 90 days** will be sent to our collection agency.

**After hours and Emergencies:**

- Please dial 911 immediately for a true medical emergency. This includes thoughts/plans of hurting yourself/others or an overdose.
- If you are having a psychiatric or substance abuse crisis and need assistance, please contact Mobile Crisis Intervention Services (MCIS):
  Northern Delaware Hotline, call: 800-652-2929
  Southern Delaware Hotline, call: 800-345-6785
- You can reach us at (302) 660-7200 for less urgent issues and medications refills. We will try to accommodate you during the next business day.

**Medical Records:**

We are required by law to keep complete medical records. Most of our medical records will be electronic, encrypted, and HIPAA compliant. Any written records including the initial consent forms, letters, outside medical records, will be kept secured. You are entitled to review your medical record at any time, unless MPS feels that by viewing your records, your emotional or physical well-being will be jeopardized. If you wish to view your records, MPS recommends that they should be reviewed with the provider to minimize any confusion or misinterpretation of medical terms.

**Confidentiality:**

The security of your sensitive information is of utmost importance to us, and providers are bound by the law to protect your confidentiality. Our use and disclosure of your medical information is made in accordance with Federal and State law. You may refer to our Notice of Privacy Practices for more information as described above. Basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary.

There are exceptions to this confidentiality, where disclosure is mandatory under the law. These situations rarely occur in an outpatient setting. If they do arise, we will do our best to discuss the situation with you before taking action.

These include the following:

- If there is a threat to the safety of others, we are required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization.
- When there is a threat of harm to yourself, we are required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety.
- In legal hearings, you do have the right to refuse our involvement in the hearing. There are rare circumstances, however, in which our providers will be required by a judge to testify on your emotional, or cognitive condition.
- In situations where epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, we are required to report this to the DMV.
- If a mental illness prevents you from providing for your own basic needs such as food, water, and shelter, we will be required to disclose information to seek hospitalization.
- In rare circumstances, we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

**Voicemail, Electronic Mail (email) and Text:**

Always be aware that email and text messaging is not a confidential means of communication. We cannot guarantee that email and text messages will be received or responded to in a timely fashion. As such, email and text messages are not an appropriate way to communicate confidential or urgent information. You may receive email, phone, and text reminders for your appointments.

Please check what applies:

❑I consent to receive automated text, email, and voice messages at my preferred number(s) noted on the form.

❑Leave my personal/clinical information about my treatment and payment on my voicemail and email.

❑Leave my personal/clinical information with the person answering/emergency contact

List name(s)_____

*I have read and fully understand patient polices, and my questions have been answered to my complete satisfaction.*

Signature of Patient/Legal Representative: _____ Date: _____

Name of Patient/Legal Representative (printed): _____

Relationship to Patient: ❑ Self ❑Legal Representative (describe relationship): _____