David J. Schopick, M.D.

PATIENT INFORMATION - Please complete all information. Thank you.

Name of Person who referred you to our office: _____

Today's Date: _____

PATIENT FULL NAME:_____

PATIENT DATE OF BIRTH: _____

SOC SEC #: _____

PATIENT EMPLOYER/SCHOOL:

_____

PATIENT OCCUPATION: _____

PATIENT MARITAL STATUS: _____

If patient is a minor child, parents' names:

Mother_____

Father _____

Mailing Address:

_____

Street Address Town/City Zip

Telephone Number:

(h) _____ (w)_____(c)_____

If parents are: _____ Divorced _____ Separated

** This is the ____mother's ___ father's information:

Other parent's mailing address:

_____

Street Address Town/City Zip

Telephone Numbers

(h) _____ (w)_____(c)_____

RESPONSIBLE PARTY (person responsible for charges/ins co-payments, etc.):

Name: _____Phone #: _____

Address if Different from above:

_____

PRIMARY INSURANCE COMPANY: (Please call your ins co to determine your benefits).

Name of Company: _____Effective Date(s): _____

INSURANCE ID#: _____GROUP/ACCT #: _____

Subscriber's Name: _____ Relation to pt. _____

Subscriber's DOB: _____

Subscribers SS#: (*necessary) _____

Subscribers Address:_____

Street Address Town/City Zip

Subscriber's Telephone:

(h) _____ (w) _____ (c)_____

Subscriber's Employer:

_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS: I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the undersigned physician.

** PLEASE BE SURE TO NOTIFY OUR OFFICE IF ANY INFORMATION ABOVE CHANGES.

_____ Date: _____

Patient or Parent/Guardian of Minor Patient

David J. Schopick, M.D.

American Board of Psychiatry and Neurology
Child, Adolescent, Adult and Forensic Psychiatry
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Please read this Policy carefully. It will help answer some of your questions, and reduce paperwork and time consuming telephone calls in the future. This agreement must be reviewed, signed, and on file prior to the start of your initial appointment. There is no need to return this document to us prior to your initial appointment - please bring it with you.

OFFICE / FINANCIAL POLICY

Our office accepts assignment for most Anthem / Blue Cross and Blue Shield plans (including Federal BC/BS, Anthem plans, Matthew Thornton), Harvard Pilgrim, Cigna, United Behavioral Health, some Healthcare Value Management, and some Health Plans, Inc. policies. If you subscribe to one of these insurance plans, payment of your deductible and co-payment is expected at the time of service. For other insurance plans not covered, please be prepared to pay in full at the time of service. If you do not have insurance, or choose not to use insurance, payment in full is due at the time of service.

Please note that we are unable to bill to secondary insurance companies.

As a courtesy to our patients we bill insurance companies. However, we will not be able to bill your insurance company as a service to you if we are not provided with the following:

1. Patient's full name and date of birth;
2. The complete name, address, telephone number, current ID #, Group # of your insurance company or company handling mental health claims for your insurance company, and the effective start and end dates of your coverage; and,
3. Subscriber's name, address, date of birth, and social security number.

You should also be aware that some insurance companies will not pay for medical services that they decide are "Not Medically Necessary" or consider uncovered services. We have no control over the workings of the insurance companies and assume no responsibility for their policies. In the event your insurance company considers a service "Not Medically Necessary" or uncovered, this in no way can be construed to mean that medical treatment and care was not rendered. You will still be expected to make payment for the service within thirty (30) days. When an insurance company refuses to make payment for medical services, the patient is then responsible for payment of these services he/she has received. If you are not satisfied with your insurance company's decision to deny payment, you are entitled to contest that denial with the insurance company. Payment for services rendered is required; however, if you pursue and win a reversal of that decision from your insurance company, we will make reimbursement for the appropriate amount when we receive payment from your insurance company.

Please be particularly aware, to assist you we will gladly bill your insurance company for services rendered; however, most insurance company policies require notification and authorization *prior to your initial appointment* for services to be covered. Regardless of whether you believe it is required for your policy, please call your insurance company *prior to your initial appointment* to confirm coverage and request proper authorization for services. If this is not completed prior to services being rendered, the session fee(s) will be the responsibility of the responsible party/patient. Once the initial authorization has been

exhausted our office will complete the necessary paperwork for subsequent sessions if your policy requires this.

PATIENTS/PARENTS/GUARDIANS ARE EXPECTED TO BE FAMILIAR WITH THE DETAILS OF THEIR HEALTH INSURANCE/MENTAL HEALTH COVERAGE. PLEASE TAKE THE TIME TO CALL YOUR INSURER AND BECOME FAMILIAR WITH THE DETAILS OF YOUR POLICY. THIS MAY INCLUDE WHETHER AUTHORIZATION AND/OR A REFERRAL IS NEEDED, WHETHER OR NOT YOU HAVE A DEDUCTIBLE, THE AMOUNT OF YOUR DEDUCTIBLE, THE AMOUNT OF YOUR CO-PAY OR CO-INSURANCE, AND THE NUMBER OF VISITS YOUR PLAN ALLOWS FOR.

**Please note that an authorization from an insurance company is not a guarantee of payment. Insurance companies may issue an authorization, but wait until receipt of the claim to either accept the claim and make payment, or deny the claim. If a claim is denied, payment of that claim becomes the patient's responsibility. We have no control over an insurance company who issues an authorization, but then denies payment of a claim.

Because of the time demands involved in completing forms and miscellaneous paperwork to be submitted to schools, camps, workers' compensation carriers, social security/disability, attorneys, etc., responsible parties/patients are responsible for the costs incurred as a result of a request to complete miscellaneous forms, retrieve and copy closed out charts, preparation of letters, or any other paperwork requested.

Payment is expected in advance for services requested outside of an appointment, including, but not limited to:

- Attendance at meetings with attorneys, schools, court appearances, depositions, and any other non-treatment time spent at the patient's request;
- Travel time to and from such meetings of any nature, court appearances, depositions, and any request for attendance;
- Preparation time to review records or any other preparation time needed for such meetings, court appearances, or meetings of any nature.

When calling to reserve time for such events as described above, please ask for the current expert witness/forensic fee schedule.

Payment for a session, whether from an insurance company or self paid, covers the session time only. Please recognize we receive many requests for letters or the completion of forms. Please plan ahead as it is often difficult to accommodate last minute requests. Requests for form/letter completion is most efficiently done in conjunction with your appointment while you are here in the office. With this in mind, please make us aware at the beginning of the session that you have such a request and we will do our best to finish your request before you leave. Please understand I cannot use another patient's appointment time to complete a form or letter on your behalf.

If your insurance company, school, attorney, or other party or facility requests a copy of the patient's records or requests communications and information from this office, the cost of such a request is the responsible party/patient's responsibility.

INSURANCE APPEALS:

If you request an appeal to your insurance company for denial of a session or prescription coverage, the appeal paperwork can be completed by either scheduling an appointment at which time the appeal documents will be completed, or the time spent on the appeal can be billed at an hourly rate if you choose to not schedule an appointment. If requesting an appeal, please provide us with all paperwork you have received from your insurance company (including the address, telephone number, facsimile number, and complete name of the insurance company handling the appeal). Appeals are extremely time consuming and often require numerous contacts with the insurance company. Please allow ample time for the paperwork to be completed and processed.

CONFIDENTIALITY:

Pursuant to New Hampshire state law, R.S.A. 329:26 "Confidential Communications" are defined as follows: "The confidential relations and communications between a physician or surgeon licensed under provisions of this chapter and his patient are placed on the same basis as those provided by law between attorney and client, and, except as otherwise provided by law, no such physician or surgeon shall be required to disclose such privileged communications. Confidential relations and communications between a patient and any person working under the supervision of a physician or surgeon that are customary and necessary for diagnosis and treatment are privileged to the same extent as though those relations or communications were with such supervising physician or surgeon ..."

The Federal law (HIPAA) also requires a minimum level of confidentiality guidelines to be followed. If an individual state has a more comprehensive policy, then clinicians must adhere to the stricter of the two. HIPAA Guidelines defer to state law when practicable. Our policy regarding Confidentiality will be based on and adhere to New Hampshire state law which is much more comprehensive.

In order to communicate with anyone (physicians, therapists, school personnel, personal representatives, spouses, parents if patient is over the age of 18, etc.) regarding your treatment, we will require a written release on file authorizing our office to speak to or provide records to another party. The only exceptions to the requirement to have a written release on file is as follows:

1. Communications with your insurance carrier regarding information needed to process your claims, obtain authorization for prescription(s), or authorize additional sessions, and will be viewed as acceptable to you by signing this Policy;
2. In the event we are contacted by emergency personnel (including, but not limited to hospital staff or police) for a medical emergency and information is needed to treat you and you are not available to provide authorization;
3. Information is needed by your pharmacy in order to fill prescription(s);
4. Parents have access to their child's records unless a Court Order exists that states otherwise; or,
5. Communication to state agencies regarding suspicion of abuse and/or neglect, or concerns regarding the potential harm to self or others. If there is a concern you may be a danger to self and/or others, this office may determine it is necessary to call the authorities and/or the intended victims to alert them of a potential danger.

REMINDER CALLS:

Reminder calls will be made to the home telephone number you have provided to us on the Patient Information sheet. If you want a reminder call made to a different number, you must advise us in writing, and this document will be kept in your patient chart for reference. Unless otherwise advised, reminder call(s) will be made to the home number you have provided to us.

As stated above, we will make every effort to provide a courtesy reminder call prior to your scheduled appointment. However, as there are three separate areas of our practice, there are days when we are not in the office, and therefore not able to place reminder calls. It is the patient's/parent's responsibility to keep track of scheduled appointments and to not rely solely on a reminder call. A reminder card will be issued when rescheduling to assist you in keeping track of your appointment(s).

LATE CANCELLATION – NO SHOW POLICY:

An important element for an effective outcome in treatment is that you set your/your child's appointment time as a priority. Cancellations and missed appointments are strongly discouraged for both therapeutic and scheduling reasons.

We require 24 hours notice if you are unable to keep an appointment. If notification is not made within 24 hours, or if the appointment is missed, you will be charged for the late cancellation or missed appointment. Notification after 5:00pm on a Friday or on a Saturday or Sunday of a Monday cancellation will not be considered timely. The charge for a missed medication management session is $50.00, and a missed initial/full session is $145.00. The fee should not be considered a penalty for missing the appointment; it is only in place to recuperate the time we had reserved for you from our schedule at your request. Insurance companies will not pay for a missed appointment or late cancellation, and payment is expected before rescheduling.

Exceptions to this policy of charging for appointments not kept and not canceled with 24 hours notice will take place only when the weather is severe enough to close public schools or an illness requires a visit to a physician.

PRESCRIPTION REFILLS:

Due to a past experience of a high number of patients calling for medication refills after not following the recommended follow-up time, or missing appointments, our policy for medication refills is as follows:

Prescriptions will be refilled during your appointment only. You are expected to follow the recommended schedule for follow-up appointments. You will not be able to pick up a prescription at the office or have our office renew a prescription by telephone. The only exceptions to this policy are in the event of a true medical emergency, a medically necessary medication or dose change, or if we have had to reschedule your appointment and your current prescription will lapse prior to the rescheduled appointment. We will not refill lost stimulant prescriptions prior to the scheduled refill date.

This policy will assist in our efforts to maintain a high level of patient care.

PRIOR AUTHORIZATIONS FOR PRESCRIPTIONS:

There are times when your insurance company will request a "Prior Authorization" from our office before they will consider paying their portion of your prescription costs. Insurance companies can take up to five business days to process a Prior Authorization request. Once we have submitted the necessary paperwork to your insurance company, we have no control over how long they will take to cinsider the Prior Authorization request, nor do we have the information available to us to know the status of the Authorization request until it is completed. If you wish to know the status of the Authorization request , please contact your insurance company directly.

PATIENT BALANCES:

We are a small practice and therefore unable to allow patients to carry a large outstanding balance on their account(s). Please come to your appointment prepared to pay your balance in full. If a third party is paying your bill, please obtain the amount due prior to your appointment to reduce the time spent on paperwork and telephone calls to collect your balance. We appreciate your assistance with this policy as it will allow us more time to focus on your needs and requests, and will help eliminate the time spent attempting to collect overdue balances.

RETURNED CHECKS:

If your check is returned to us by the bank as unpaid for any reason, a returned check fee of $25.00 will be added to the amount of the check written. The $25.00 fee represents the fee the bank charges us and the administrative cost to handle the extra processing and will be paid in full within ten (10) business days.

CASE CLOSURE:

If there has been no clinical contact after a period of four months, we will assume you have decided to discontinue treatment. At this point, you will no longer be considered a current patient and your chart will be closed and placed in storage. If you wish to resume your treatment, you may simply contact the office and request a re-evaluation. A decision of whether or not to resume treatment will be made at this time.

Your signature below indicates that you understand and agree to our Office / Financial / Confidentiality Policy in its entirety, including, but not limited to your agreement that: you assign all insurance benefits directly to our office, will pay deductibles, co-payments, any requested service not covered by insurance as explained above, will pay for late cancellations or no show appointments, and for returned checks.

We will be happy to speak with you about any questions you may have.

Signature_____ Date _____

Patient or Responsible Party