Biological Psychiatry Center, P.C.

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Dear Client: Welcome to BPC!

- Thank you for contacting BPC to schedule your or your child's appointment. Please find attached our New Patient forms. These forms must be completed in its entirety in order for an appointment to be completed. Once completed, you may email, mail or hand deliver the forms to our office. Our email address for forms submission is: forms@bpcpc.com. Once the New Patient forms along with a copy of your ID and insurance cards are received by the office, we are able to schedule your or your child's appointment. (For minors, ID is needed of both parents.) Our office staff will witness all of the enclosed forms for you.

- **Please email, fax, mail or hand deliver:** List of Medications, Blood work (CBC with diff / SMA20 / TSH), most recent physical, EKG's and/or MRI's performed within the last 12 months by your Primary Care Physician and your Specialist.

- **If the patient is a minor**, a parent or legal guardian must be present at the appointment and **both parents must** sign the forms (If a parent or legal guardian is not present, the minor cannot be seen due to legal reasons). **If custody arrangements are in place for payments, please know that we respect the court's decision but our office expects payment at the time of the appointment and the parent bringing the child must make payment - no exceptions.** Our office is able to provide detailed receipts of payment.

- **Please confirm your appointment by calling our office before 7:00 P.M. one day prior to your appointment.** Our voicemail system is on 24 hours, 7 days a week. Call (586) 773-6020 ext. 0. Failure to do so could result in your appointment being cancelled.

- **Please log in at least 5 minutes prior to the scheduled appointment. Also, please test connection prior to your scheduled appointment date.** All links for telehealth appointments are available on our website at **www.bpcpc.com**

- **If the patient is a minor** and there are any legal custody arrangements regarding medical decisions and treatment in place through the court system, please bring the paperwork to the initial appointment so we may copy them for our records**.**

- **Verify your outpatient mental health benefits before your appointment.** It is your responsibility to know your coverage. Please call your insurance and request your outpatient Mental Health Benefits and complete the information below and submit it with all other attached forms.

Number called: _____ Date of Call: _____ Time of Call: _____

Spoke With: _____ Reference Number of call: _____

$_____ Ded / $_____ Copay & or _____ Coins / _____ Visit limits / Authorization Needed: Y N

- **Please call our office to find out your financial obligation as quoted by your insurance carrier. Payment is expected at the time services are rendered.** As a courtesy our office will attempt to verify your benefits one day prior to your appointment. All Deductible, Copayments and Coinsurance will be collected prior to being seen. Our office accepts payment by cash, check, credit and debit cards.

Please don't hesitate to call us at **(586) 773-6020** if you have any questions. We look forward to seeing you. Thank you.

Biological Psychiatry Center, P.C.

Office Address: 25869 Kelly Road, Suite A; Roseville, Michigan 48066
Telephone: (586) 773-6020 · Fax: (586) 773-6093 - Website: www.bpcpc.com

UPDATED 01/27/2021

BIOLOGICAL PSYCHIATRY CENTER, P.C. **PATIENT DEMOGRAPHIC FORM**

DATE: _____/_____/_____ **PATIENT NUMBER: _____**

Last Name:_____ **First Name**:_____ **Middle Name**:_____

Address:_____**City**:_____ **State**:_____ **Zip code**:_____

Cell #: (____)_____ **Home #**: (____)_____ **Alt #:** (____)_____

Our office utilizes HIPAA compliant programs to send appointment links, appointment reminders, payment links and payment reminders as a way to communicate with patients. May we text you at the number listed above? Yes / No

E-Mail: _____ **Social Security #:** _____/_____/_____ **Employed:** Yes / No

Employment Status: Part-Time / Full Time / Retired / Other: _____ **Employer**: _____

Family Doctor: _____ **Phone#:** (____)_____ **Address**: _____

Neurologist: _____ **Phone#:** (____)_____ **Address**: _____

Mental Health Therapist:_____ **Phone#:** (____)_____

REQUIRED FOR MINORS:

Fathers Name: _____ **DOB:** _____/_____/_____ **Cell#:** (____)_____ **Home#**: (___)_____

Mothers Name: _____ **DOB:** _____/_____/_____ **Cell#:** (____)_____ **Home#**: (___)_____

School Name: _____ **Phone#:** (____)_____ **Counselor**: _____

Address: _____ **Accommodations in Place:** IEP / 504 / Other:_____

DEMOGRAPHIC INFORMATION (Required to collect data per CMS Guidelines)

Date of Birth: _____/_____/_____ **Sex: Male / Female / Other: _____**

Language: English / Italian / Spanish / Polish / German / French / Other: _____

Religion: **Catholic / Protestant / Jewish / Hindu / Islamic / Buddhist / Other: _____**

Race: Caucasian / African American / Hispanic / Asian / Native American / Other: _____

Ethnicity: Non-Hispanic or Non- Latino / Hispanic or Latino / Declined to Provide / Other: _____

OPTIONAL

Annual Household Income: Below $10,000 / $10,000 - $30,000 / $30,000 - $50,000 / $50,000 - $70,000 / $70,000 and Above

REFFERAL INFORMATION - Referred to Biological Psychiatry Center, P.C.:

By: Family member / Friend / PCP / Therapist / Neurologist / Other medical specialist: _____

Do you have other family members in treatment at our office: No / Yes - Name: _____

Have you had psychiatric treatment this year? No / Yes - Name: _____

PHARMACY INFORMATION

Mail Away Pharmacy Name:	**Address:**	**Phone: ( )**
Local Pharmacy Name:	**Address:**	**Phone: ( )**

EMERGENCY NOTIFICATION (REQUIRED) - In Case of Emergency Notify:

Name: _____ **Relationship**: _____

Home #: (____)_____ **Cell #**: (____)_____ **Alt #**: (____)_____

I hereby give consent to contact the above-named person if I require emergency care / hospitalization.

_____

Patient / Guardian Signature

BIOLOGICAL PSYCHIATRY CENTER, P.C.
HIPAA Privacy Policy Form

By signing this form, I consent to the use or disclosure of my Protected Health Information by my provider Biological Psychiatry Center (BPC) and its professional, clerical, and billing staff for purposes of treatment, payment and healthcare operations. This is a joint consent form of BPC and its clinical staff.

Protected Heath Information means health information (including identifying information about me) collected from me or received by BPC, another provider, a health plan, my employer or a health care clearinghouse. It may include information about my past, present or future physical or mental health or condition, the provision of my health care and payment for my health services.

BPC agrees to maintain my Protected Health Information in accordance with the practices described in the BPC Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my Protected Health Information.

I acknowledge that I have been given a copy of the BPC Privacy Notice and I have been given an opportunity to review the BPC Privacy Notice prior to signing this consent.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by my Assigned Clinicians and other staff

I also understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that BPC has taken action in reliance upon this Consent.

I, _____, authorize BPC and its professional, clerical, and billing staff members to contact **myself,** at the following numbers, regarding any appointment, medical, and billing issues.

Home #: (_____) _____ **Cell#:** (_____) _____
Work #: (_____) _____ **Alt #:** (_____) _____

Patient / Guardian Signature: _____ **Date:** _____

I, _____, authorize BPC and its professional, clerical, and billing staff members to contact **spouse / relative** regarding any appointment, medical, and billing issues.

Spouse: _____ **Relative:** _____
(Name) (Name & Relationship)

Home #: (_____) _____ **Home #:** (_____) _____
Cell #: (_____) _____ **Cell #:** (_____) _____
Work #: (_____) _____ **Work #:** (_____) _____
Alt #: (_____) _____ **Alt #:** (_____) _____

Patient / Guardian Signature: _____ **Date:** _____

Patient Name: _____ **DOB:**_____

BIOLOGICAL PSYCHIATRY CENTER, P.C. **NEW PATIENT FORM**

Patient's Name: _____ **Acct#:** _____ **DOB**: _____ **Age**: _____ **Date:**_____

Are you experiencing problems with or diagnosed with:	**Specify Medical Condition(s):**
1. General Health	□ No □Yes _____
Date of Last visit with Internist / PCP: _____	Date of Last Physical: _____
2. Eyes: date of last Exam: _____	□ No □Yes _____
3. Ears / Nose / Mouth or Throat	□ No □Yes _____
4. Heart / Blood Pressure	□ No □Yes _____
5. Lungs	□ No □Yes _____
6. Stomach or Intestinal	□ No □Yes _____
7. Urinary / Gyn	□ No □Yes _____
8. Bone / Joint Pain	□ No □Yes _____
9. Skin	□ No □Yes _____
10. Brain	□ No □Yes _____
11. Diabetes / Thyroid	□ No □Yes _____
12. Blood / Lymphatic	□ No □Yes _____
13. Allergies	□ No □Yes, please list below:

Allergy:	Medication Related:	Reaction and Severity:

Brief History

DO YOU:		If yes, please specify:
Consume tobacco:	Yes or No	Cigarettes / Cigar / Pipe / Chew Frequency:
Consume alcohol:	Yes or No	Social / Occasional / Daily
Consume illegal drugs:	Yes or No	Social / Occasional / Daily
Exercise:	Yes or No	Occasional / Daily
Have dietary restrictions:	Yes or No	Vegetarian / Other
Have children:	Yes or No	How many:
Reside in an: Apartment / Home / Other:		Reside with: Parents / Siblings / Spouse / Alone / Other:
Ethnic, cultural, religious or linguistic preferences staff should be aware of:	Yes or No	

List of all Medication Names and Dosages Prescribed (previous and current): (If additional space is required please write on back)

1.	5.	9.
2.	6.	10.
3.	7.	11.
4.	8.	12.

Hospitalization Information (within the last 1-2 years): **□ None** **(If additional space is required please write on back)**

Hospital Name:	Dates of Hospitalization:	Reason for Admission:

BIOLOGICAL PSYCHIATRY CENTER, P.C.

25869 Kelly Road, Suite A; Roseville, MI 48066 | (586) 773-6020

Consent for Treatment

Biological Psychiatry Center, P.C. (BPC) is a private, comprehensive, full-service psychiatric facility serving southeastern Michigan operating under the guidelines of the Michigan Psychiatric Society, Council of Accreditation, Blue Cross Blue Shield of Michigan, and the Department of Mental Health.

- I authorize Dr._____ and delegated associates to give the psychiatric treatment they think necessary according to their professional judgment. I understand that I should discuss any treatment concerns with BPC professional staff.
- I understand if the appointment is for a minor, a parent or legal guardian must be present for the appointment.
- I agree to allow my doctor, delegated associate, or office staff to perform medication reconciliation through the electronic health system in order to obtain current and accurate medication information for my/my child's records.
- I understand that my doctor may prescribe medications as part of my treatment. Although approved by the Food and Drug Administration, these medications may have side effects, both known and unknown.
- I acknowledge that no one at BPC has given me an oral or written guarantee about the results, risks, consequences, or complications of psychiatric treatment.
- I recognize that physicians, psychologists, social workers, and other psychiatric professionals may be involved in my psychiatric treatment at BPC. Treatment methods may include, in office, by synchronous and or asynchronous (audio/video; telephone or email).
- I understand that the office complies with all CMS Medicare guidelines and will perform all mandatory tasks set forth by the agency and may disclose my medical information without written authorization.
- I understand that my records are confidential and protected by law. BPC will ask for my signature on a consent form before they disclose or request any information about me. I also understand that under certain circumstances outlined in BPC's **Notice of Privacy Practices** and permitted by **HIPAA** and Michigan state law, BPC may disclose my medical information without written authorization.
- I agree to fully participate in my treatment plan throughout my care. **If I miss 2 or more consecutive appointments, the office has the right to close my case at BPC for non-compliance and no further appointments will be scheduled.**
- I understand that I can revoke this Consent of Treatment and/or Fee Agreement at any time by submitting a signed letter and that doing so will end my treatment at BPC.

Fee Agreement

I UNDERSTAND BY SIGNING THIS DOCUMENT THAT:

- **I understand it is my responsibility to verify my benefits and BPC staff is available to help interpret the benefits but ultimately any amount not paid by my insurance carrier for any reason is my responsibility. It is my responsibility to provide current insurance information at the time service is rendered. If claims are rejected due to incorrect information provided, the balance is my responsibility. I am responsible for paying all Deductible, Copayments, Co-insurances or any other balances at the time of my appointment. I am responsible for paying all charges that are not covered by insurance benefits.**

- **I have received and reviewed BPC's financial policy regarding missed appointments. I may be charged a minimum fee of $50 for a missed appointment or appointments not cancelled with at least 24 hour notice with a psychiatrist (MD or DO) and at least 48 hour notice with a therapist (Ph.D., LLP, LMSW, LPC) of the scheduled time. I understand that my insurance carrier will not cover this charge.**

- **I will be charged $25 per Letter and/or $25 per page for any forms completed on my behalf except those that are coordinating treatment with my Primary Care, Referring Physician and/or Health Care Specialist. I understand that BPC does not complete any disability paperwork or perform any disability evaluations.**

- **In order for Biological Psychiatry Center, PC to service my account or collect any amounts I may owe**, Biological Psychiatry Center, PC and its third-party billing and/or debt collection service providers may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, text messages and email, which may result in charges to me. Additionally, I authorize contact via text messages or e-mails, using any e-mail address I provide. Methods of contact may include using pre-recorded/artificial voice message and/or use to an automatic dialing device, if applicable.

My signature confirms that I have read, had the opportunity to discuss, fully understand, and agree to this Consent for Treatment and Fee Agreement and that I received a copy.

Patient or Guardian Signature[1]:_____ Date: _____

Patient Name:_____ Date of Birth: _____

[1] *Parent/guardian* indicates that patient is a minor or under care of legally recognized guardian.

Telepsychiatry and Teletherapy are the delivery of psychiatric and/or therapeutic services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect client information and safeguard the data exchanged. There are requirements, potential benefits, potential risks, rights and responsibilities associated with Telepsychiatry and Teletherapy services. These services are not meant to replace in-person care but to enhance it.

REQUIREMENTS:

- Client must be an active established client with Biological Psychiatry Center, P.C. and a resident of the State of Michigan.
- A computer with a web camera and microphone to video conference; iPad; tablet; cellular phone or other similar electronic device that is able to access Doxy.me or other similar HIPPA compliant online company specializing in telemedicine.

POTENTIAL BENEFITS:

Telepsychiatry and Teletherapy provides convenience and increased accessibility to psychiatric care for clients who are unable to be treated face-to-face due to temporary circumstances such as physical limitation, being away at an in-state college or an extended stay away from home which prevents a client to travel to our office.

POTENTIAL RISKS:

There may be potential risks associated with the use of Telepsychiatry and Teletherapy. They include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video, internet connection) to allow for appropriate medical decision making.
- Psychiatrist and/or Therapist may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

ALTERNATIVES TO THE USE OF TELEPSYCHIATRY AND TELETHERAPY:

Traditional outpatient face-to-face sessions are the best alternatives to Telehealth services.

RIGHTS:

- You have the right to revoke (withdraw) your consent to the use of telepsychiatry during the course of your care at any time.
- The laws that protect the privacy and confidentiality of medical information also apply to Telepsychiatry and Teletherapy.
- The Telemedicine technology used by Biological Psychiatry Center, P.C. is HIPAA complaint and protected to prevent the unauthorized access of your private medical information,
- The distribution or broadcasting of any personally identifiable images or information from the Telepsychiatry and/or Teletherapy interaction to researchers or other entities shall not occur without your written consent.
- All the rules and regulations which apply to the practice of medicine in the State of Michigan also apply to telepsychiatry.
- You understand that any or all Biological Psychiatry Center, P.C. clinicians have the right to revoke (withdraw) consent for the use of Telepsychiatry and/or Teletherapy at any time during the course of your treatment if they feel that it is not safe or meets the professional standards of care.

RESPONSIBILITIES:

• You understand a parent / legal guardian must be present for the appointment if Telehealth services are for a minor.

• You will not record any Telepsychiatry or Teletherapy sessions without the consent from Biological Psychiatry Center, P.C. clinicians and Biological Psychiatry Center, P.C. clinicians will not record any of the Telepsychiatry and Teletherapy sessions without my consent.

• You will inform our clinicians if any other person can hear or see any part of the session before the session begins and Biological Psychiatry Center, P.C. clinicians will inform you of any other person can hear or see any part of the session before the session begins.

• You understand that Biological Psychiatry Center, P.C. psychiatrists and therapists determine whether or not the condition being diagnosed and/or treated is appropriate for telehealth sessions.

• You understand that if the Telepsychiatry and/or Teletherapy session is not deemed appropriate, the psychiatrist or therapist may require a face-to-face visit in the office or refer you for higher level of care such as partial hospitalization or inpatient services.

• You are responsible for the configuration of any electronic equipment used to access Telepsychiatry and Teletherapy prior to the start of the session.

• You understand every Telepsychiatry or Teletherapy session needs to be a scheduled appointment and will be held to the same policies as a face-to-face appointment. All balances, copayments and or coinsurances will be collected when the appointment is scheduled. Missed calls will incur a No-Show Fee. Any calls made after the scheduled time may need to be rescheduled and may incur a Late Arrival/Cancelation Fee. Please refer to our Financial Policy for specific No Show and Late Cancelation charges.

• You understand that the office makes no guarantees that your insurance company will pay for these services in part or full. It is your responsibility to call and verify that Behavioral Telehealth services are a covered benefit under your plan.

• You will be responsible for payment of any non-covered charges, deductible, co-payment and co-insurance applied by your insurance company for Behavioral Telepsychiatry and Teletherapy services. For your convenience, we have provided an insurance verification form so you may document your insurance benefits as quoted by your insurance company.

• You understand that you may be asked to verify your identity at your initial evaluation. Failure to provide appropriate identification will result in your appointment being canceled.

• You understand that you must be a resident of the State of Michigan to be eligible for Telepsychiatry and Teletherapy services.

CONSENT FOR TELEPSYCHIATRY AND/OR TELETHERAPY SESSIONS:

You consent to receive SMS messages from Doxy.me, OhMD and other HIPAA compliant appointment / task reminder service providers (data and messaging rates may apply). You are authorizing Biological Psychiatry Center, P.C. clinicians to use Telepsychiatry and/or Teletherapy in the course of your diagnosis and treatment. Your signature below indicates that you have read and understand the information provided above regarding Telepsychiatry and/or Teletherapy services.

Patient Name:_____ **Date of Birth:** _____

Patient / Legal Guardian Signature: _____ **Date:** _____

If Legal Guardian, please print Name and Relationship: _____

Created: 03/20/2020
Updated:09/11/2021

Biological Psychiatry Center, P.C.
Controlled Substance Contract

The purpose of this contract is to protect your access to controlled substances and to protect our ability to prescribe to you.

Many of the controlled substances prescribed for ADD/ADHD, Anxiety, Panic disorder and Sleep disorders have potential for abuse. Properly monitored use of the controlled substance is extremely important to prevent any abuse. Hence, it is important that you follow these instructions.

Failure to follow instructions may result in termination of patient-doctor relationship at Biological Psychiatry Center, PC (BPC,PC) .

1. I will inform my physician of any current or past substance abuse, or any current or past substance abuse of any member of my immediate family.

2. I will obtain all controlled substances from the same pharmacy. Should the need arise to change pharmacies; I will inform all of my providers in advance. The pharmacy I am selecting is: _____(pharmacy) _____(phone)

3. I will inform the office of any new medications or medical conditions, and of any adverse effects I experience from any of the medications that I take.

4. I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists or other professionals who provide my health care for purposes of maintaining accountability.

5. I will not allow anyone else to have, use, sell or have access to these medications.

6. All prescriptions will be sent electronically unless it is deemed necessary by the physician to provide a written prescription.

7. I will take my medication as prescribed and I will not change the prescribed dose.

8. I understand that these drugs should not be stopped abruptly, as withdrawal syndromes will likely develop. If you abruptly discontinue these medications due to overuse, we will be unable to refill your medications as you will be required to see emergency care.

_____ _____

Date Print: Patient Name & Date of Birth

Biological Psychiatry Center, P.C.
Controlled Substance Contract

9. At my doctor's discretion, I will cooperate with unannounced urine or serum toxicology screens that may be requested.

10. I understand that the presence of unauthorized substances may prompt referral for assessment for a substance abuse disorder and/or discharge from the practice.

11. I understand that these drugs may be hazardous or lethal to a person who is not tolerant to their effects, especially a child. For their safety, I agree to keep such medications out of reach and in a secure place.

12. I understand that medications may not be replaced if they are lost, damaged, or stolen. I further understand that I may possibly be discharged from the practice if I request an early refill because the medications or prescriptions are lost, damaged, stolen or have increased my dose without discussing this with my physician.

13. If the responsible legal authorities have questions concerning my treatment, as may occur, for example if I obtained medication at several pharmacies, all confidentiality is waived and these authorities may be given full access to my full records of controlled substances administration.

14. I understand that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribed by this physician or referral for further specialty assessment.

15. ***I will keep my scheduled appointments in order to receive medication renewals.

16. I have been explained the risks of psychological addiction, physical dependence, withdrawal and over dosage.

17. **I understand that my physician is required by State of Michigan new Legislation 176 to obtain a Controlled Medication Prescription records from MAPS (website maintained by the State of Michigan) prior to issuing any controlled substance medications.**

18. I affirm that I have full right and power to sign and be bound by this agreement, and that I have read, understand and accept all of its terms.

19. I am aware that attempting to obtain a controlled substance under false pretenses, is illegal and I will be terminated from treatment at BPC, PC.

_____ _____

Patient / Legal Guardian Signature | Print: Legal Guardian Name & Relationship

_____ _____

Date | Print: Patient Name & Date of Birth

BIOLOGICAL PSYCHIATRY CENTER, P.C.

25869 Kelly Road, Suite A
Roseville, MI 48066
(586) 773-6020

Authorization for BPC to Release Patient Information to Insurance Carrier and/or Primary Care Provider (PCP)

Patient Name: _____ **Birth Date**: _____ **SSN**: _____

Patient Address: _____
(No./Street/Apt.) (City/State/Zip)

- **I authorize BPC to release the following information for the purpose of:**

Billing insurance for services rendered
1. Date of Service 3. Procedure Code 5. Facility Name
2. Diagnosis 4. Provider Name 6. Session Notes

☐ _____
(Insurance Carrier)

_____
(No./Street/Ofc. No.)

_____
(City/State/Zip)

~ I am a Private Pay Patient and have received Fee Schedule. _____ (initials)

Coordinating of Care with Primary Care Physician
1. Date of Service 3. Prognosis 5. Treatment Plan
2. Diagnosis 4. Medications 6. Any Referrals made

☐ _____
(Primary Care Physician / Family Doctor)

_____
(No./Street/Ofc. No.)

_____
(City/State/Zip)

~ I do not want coordination with my PCP or Healthcare provider to occur. _____ (initials)

- **This authorization expires on: _____** (specify expiration date or event)
  (If left blank, this release will remain active for the duration of your treatment at BPC.)

- I understand that can revoke this authorization at any time by submitting a signed letter to: Biological Psychiatry Center, PC, 25869 Kelly Road, Suite A; Roseville, MI 48066. Revocations will not apply to information that has already been released. The authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

- I understand that, I as the client/parent/guardian who signed this form, can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, and any other applicable laws, rules and regulations.

- I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentially Laws (P.L. 104-191 (HIPAA), 45 CFR Parts 160 and 164).

- I am giving this consent voluntarily and have been informed of the specific information to be released.

Patient or Parent/Guardian Signature[1]: _____ Date: _____

BPC Person Executing Request: _____ Date: _____

[1] *Parent/guardian* indicates that patient is a minor or under care of legally recognized guardian.

Biological Psychiatry Center, P.C.

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Denise Kelly, L.M.S.W
Mary DeCarolis, L.M.S.W.

Updated Late Cancellations or No Show Fee Policy for Therapists:

Effective: July 29, 2020

Due to the high demand for our Therapist's services, the office late cancellations and no show policy is as follows:

1. You must give 48 hours' notice to cancel an appointment.
2. You will be billed at the rate of $50.00 for the first late cancellations and/or no show.
3. You will be billed at the rate of $100 for the second late cancellation and/or no show.
4. You will be billed at the Full Biological Psychiatry Center, P.C. rate of session for the third and following late cancellations and/or no show.
5. In order to be scheduled for any follow-up visits, all balances must be paid in full or payment plan must be set up with the office.

I have read the above changes and agree to comply with this policy.

_____ _____
Patient Signature Date

_____ _____
Therapist Signature Date

Office Address: 25869 Kelly Road, Suite A · Roseville, Michigan 48066 · (586) 773-6020 · Fax: (586) 773-6093

Biological Psychiatry Center, P.C. - Financial Policy

Biological Psychiatry Center, P.C (BPC) financial policy describes the patients and practices financial responsibilities. We are committed to providing our patients with the best possible medical care and also to minimize administrative costs. This policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- BPC participates with numerous insurance companies and will submit a claim for services rendered. It is the patient's responsibility to provide us with current insurance information. Copies of Insurance cards and ID should be emailed to forms@bpcpc.com prior to the scheduled appointment or can be brought with you to your scheduled appointment. In the event that the insurance cannot be verified either prior to or at the time of the appointment, we will ask that services are paid in full at time of visit. If payment cannot be made, we will ask that your appointment be rescheduled.
- If our office does not participate with your insurance, we will file a claim upon request however payment in full is expected at time of service.
- It is the patient's responsibility to pay any deductibles, copayments, or any portion of the charges as specified by your insurance plan including non-covered services at the time of visit. If payment is not made at the time of service, a $10 service charge will be charged to your account.
- Majority of insurance carriers place restrictions that they will not cover individuals' claim that see a therapist and psychiatrist on the same day. If you chose to see a therapist and psychiatrist on the same day, and your insurance carrier denies claims, you will be responsible for payment in full for services rendered.
- It is the patient's responsibility to remember their appointments. If you do not cancel with at least a 24-hour notice with MD/DO or 48 hours with a therapist and/or no show for your scheduled appointment with your psychiatrist, charges will be as follows:

MD/DO	15-minute appointment $50	30-minute appointment $100	45-minute appointment $150
Therapist	1 missed appointment $50	2ND missed appointment $100	3RD + missed appointment – Full Fees

- Our cancelation policy will be strictly enforced. The cancelation/no-show charge cannot be billed to your insurance company. You will be responsible for paying the fee prior to being rescheduled. In addition, if you miss 2 or more consecutive appointments, you may be discharged from the practice for non-compliance.
- Payment for services can be made in person, by phone (586) 773-6020 or online at www.bpcpc.com. Payment methods accepted are cash, check or credit card. If payment is not made by end of business, a $10 service fee is added to your account.
- We will send a maximum of two statements in an attempt to collect any unpaid balances. Finance charges will be added to your account if a balance is 60 days past due. If the account is referred to our collection agency you and your family member will be dismissed from the practice. In the event this action occurs, you will be asked to pay the entire balance in full and any additional costs to the practice incurred from the collection agency before any future appointments can be considered.
- Our staff is happy to help with any insurance questions relating to how a claim was filed, or regarding any additional information needed to process the claim. Specific coverage issues however can only be addressed by the insurance carrier's member services department. (Phone number should be listed on back of your insurance card.)
- The adult accompanying a minor and parents or guardian of minors are responsible for payment at the time of service. For any unaccompanied minors, payment must be made prior to the scheduled appointment unless prior arrangements have been made with the billing department.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the practice. We are here to help you.

BIOLOGICAL PSYCHIATRY CENTER, P.C.

The Patient-Provider Partnership - Specialists Agreement (Patient Copy)

At Biological Psychiatry Center, P.C., we strive to create a welcoming and supportive atmosphere where you feel heard, respected, and comfortable throughout your healthcare experience. We are committed to providing compassionate care in a positive and friendly environment. The health and wellness of our patients is a top concern of this office. Providing the best possible specialty care to every patient is our primary goal. Your care will be coordinated with your Primary Care Physician. Below are some guidelines to make the best of this partnership.

As our patient, your responsibilities are to:

- Promote positive behavior by being respectful and kind to other patients and staff. Any negative behaviors are not acceptable and will be addressed accordingly.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Participate, by attending all scheduled appointments and commit to the treatment plan that has been developed for you
- Follow through with recommended testing and contact our office if you are unable to get these tests completed
- Be sure you understand the treatment plan, if not ask questions
- Tell us immediately if you are unable to follow your recommended treatment plan so we can modify it for you to receive the best results possible
- Be honest about your history, symptoms and other important information about your health
- Tell your psychiatrist or therapist any changes in your health and wellbeing
- Follow up with your Primary Care Provider for overall healthcare needs
- Provide us with your e-mail address so we can provide patient education regarding medications and diagnosis through portal

As your provider office, our responsibilities are to:

- Promote positive behavior by being respectful and kind to BPC, PC patients. Any negative behavior will not be tolerated and will be addressed accordingly by administration.
- Schedule your appointment as soon as possible
- Communicate regularly with your Primary Care Provider to make sure we coordinate your care
- Consider all your needs when we work with you to develop a treatment plan related to the reason for your referral
- Provide 24-hour access to medical care and same day appointments, whenever possible.
- Provide instructions on how to meet your health care needs when the office is not open – Urgent Cares listed below
- Provide information to help you learn how to self-manage your condition and assist with establishing goals for this condition.
- Provide you with clear directions about medicines and other treatment options
- When necessary, direct and coordinate your care through referrals to appropriate community resources
- End every visit with clear instructions about your diagnosis, expectations, treatment goals and future plans

Office hours:
Monday - Thursday 8:30am to 7pm / Fri 8:30am to 5pm

Office closed the following Holidays:
New Year's Eve & Day*; Memorial Day; July 4th; Labor Day; Thanksgiving Day & Friday; Christmas Eve & Day*
*Additional days may be affected, please call to verify office hours

For after-hours medical care, please proceed to the following Urgent Care Centers or Emergency Rooms.

URGENT CARE: (Hours: 8am to 8pm Daily)

MyHealth Urgent Care – St. Clair Shores: 25515 Harper, St. Clair Shores, MI 48081 **Phone:** 586-435-0160
MyHealth Urgent Care – Macomb Twp: 18200 23 Mile Road Macomb Twp., MI 48044 **Phone:** 586-992-5500

EMERGENCY ROOMS: (Hours: 24 hours / 7 days per week)

Henry Ford St. John Hospital – Detroit: 22101 Moross Road Detroit, MI 48236 **Phone**: 313-343-3400
Henry Ford St John Hospital – Macomb Twp: 17700 23 mile Road Macomb Twp., MI 48044 **Phone**: 586-416-7500

NEED HELP? 2-1-1 is now available. **Dial 211** from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health and social needs (i.e., utilities, housing, health insurance, food, diapers, etc.) A listing of the area resources can also be found on this website: http://www.referweb.net/uwjc

Thank you - Biological Psychiatry Center, P. C.

Patient Name:_____ **Date Received:**_____ **Parent:**_____

Biological Psychiatry Center, P.C.

Stanley Stanczak, L.M.S.W., Ph.D.
Michael Horwitz, A.C.S.W.
Diane Russell, L.M.S.W.
Haresh Mehta, M.D.
Kathrine Mobisson, M.D.
Francesco Iacobelli, D.O.
Mary Koukios, A.C.S.W.
Denise Kelly, A.C.S.W.
Mary DeCarolis, L.M.S.W.

Dear Client:

If you are currently in treatment with a Mental Health Therapist, Neurologist or any other physician or medical provider and wish for coordination of care, please complete the following General Release of Information Form. You will need to complete one form for each provider. For example, if you are seeing a mental health therapist and neurologist, you will need to complete 2 release forms. Please feel free to make as many copies as you need. Listing multiple providers on one form will make the form invalid.

Please don't hesitate to call us at **(586) 773-6020** if you have any questions. We look forward to seeing you.

Thank you,

Biological Psychiatry Center, P.C.

Insurance Verification Form

Date:_____ **Time:**_____ a.m p.m **Person Calling:** _____

Insurance:_____ **Telephone #:**_____

Rep Name and Reference Number: _____

Patent First Name:_____ **Last Name:**_____

Member ID:_____ **Date Of Birth:**_____

Effective Date:_____

Deductible: Yes / No Individual $_____ Met:$_____ / Family $_____ Met:$_____

Copayment: $_____ **Coinsurance**: Yes / No – If yes $_____

Out of Pocket Maximum:

Individual OOP? Yes $_____ Met $_____ Remaining $_____

Family OOP? Yes $_____ Met $_____ Remaining $_____

Is Telemedicine covered? Yes / No If yes, **Authorization required**? Yes / No

Is there a limit of Telemedicine visits? Yes / No **Is the GT modifier recognized**? Yes / No

Would an evaluation and management codes be covered with a GT modifier or 95 modifier?

Are the following Codes covered: (Indicate which codes are covered by circle)

90785 / 90791 / 90792 / 90832 / 90833 / 90834 / 90835 / 90836 / 90837 / 90846 / 90847 /

99441 / 99442 / 99443 / 98966 / 98967 / 98968 / 99212 / 99213 / 99214 / 99215 /

Testing Codes:

96127 / 96130 / 96131 / 96132 / 96133 / 96136 / 96137 / 96138 / 96139

If yes, **Authorization required**? Yes / No **Does Deductible apply to testing?** Yes / No $_____

Does Copay / Coin apply? Yes / No $ _____

Are there limitation on who can administer testing? MD / DO / PHD / LMSW / Technician

Additional Notes:_____

_____

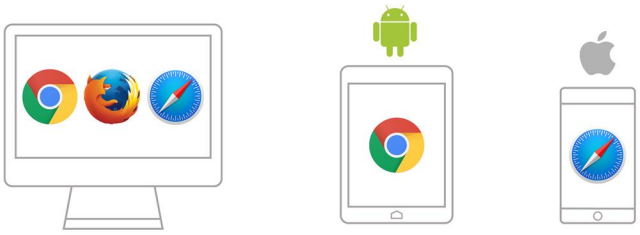
_____

Created: 03/20/2020
Updated:02/11/2021
Updated:03/20/2023

GETTING STARTED FOR CLIENTS

How to check in for your video visit

1 Use a computer or device with camera/microphone



PC and Mac
Chrome | Firefox | Safari

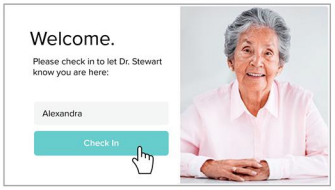
Android
Chrome

iOS
Safari

2 Enter your clinician's doxy.me web address into the browser

3 Allow your browser to use your webcam and microphone

4 Type in your name and click check in



- ✓ Secure
- ✓ No software to download
- ✓ HIPAA compliant
- ✓ No registration needed

5 Your care provider will start your visit

Call Tips

- Make sure you have a good internet connection
- Restart your device before the visit
- Test your camera and mic from the waiting room
- Need help? Send us a message https://doxy.me