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TREATMENT INFORMATION AND CONSENT FORM

NATURE OF THE THERAPEUTIC RELATIONSHIP. Our work together may involve psychotherapy and/or medications. Either treatment requires an active engagement on your part—to talk about your life openly and honestly and/or to take the medication as recommended and work with me about any difficulties that arise. Your relationship with your psychiatrist is a professional and therapeutic relationship. In order to preserve this relationship, it is imperative that the psychiatrist not have any other type of relationship with you. Personal and/or business relationships undermine the effectiveness of the therapeutic relationship. I care about helping you but I am not in a position to be your friend or to have a social or personal relationship with you.

PSYCHOTHERAPY. Since the goal of psychotherapy is to help you see things about your life in a new way, it may at times reveal painful aspects of your life or stir emotional distress. The working relationship of psychotherapy is unique. Feelings about me may be a very important part of the treatment, and we should discuss them regardless of whether they are negative or positive. Although it is unlikely, there is a possibility that treatment could make you feel worse or uncover more severe illness, in which case I would, with your permission, take all appropriate steps to help you overcome this.

MEDICATIONS. I will explain the important side effects of any medication I prescribe for you. If you encounter unexpected difficulty with the medication, please call my office immediately to discuss the problem and consider whether any changes are needed in medication or dosage. Please check your medication supply before our scheduled visits, so we can take care of prescriptions then rather than having to handle refills on the phone as your supply is running out.

AVAILABILITY. I do not accept calls when I am with clients, but will call back as soon as possible when you leave a message. Routine questions, appointment scheduling, or medication requests are best handled during the working day when my records are available to me. In the evenings or weekends when I am in town, please listen carefully to the voice mail message for instructions on how to reach me at another number. I'll try to give you advance notice before any event that interferes with our scheduled visits. When I'm away, a trusted psychiatric colleague with training and orientation similar to mine will be available. His or her name and phone number will be on my voice mail's outgoing message.

If you can't reach me or the physician covering for me quickly in an emergency, call 911 or go to a hospital emergency room.

FINANCIAL POLICY. Payment for services is due at the time they are rendered. I accept cash and check for payment. I do not bill insurance companies, but will provide a receipt so that you may receive reimbursement if you wish. Since I am not on any insurance provider panels, I will be considered and *out of network provider*, and different benefits may apply for reimbursement. I am committed to providing the best treatment for my patients and I charge what I believe to be reasonable and customary fees, comparable for psychiatrists practicing in this region. Much of my decision to abstain from insurance panel participation and billing has to do with the increased overhead it would invariably produce, leading to increased fees and adversely interfering with the work for which I was trained, providing competent and attentive psychiatric care.

Overdue accounts may be referred to a collection agency as a last resort. Any legal fees that I must pay to secure past due balances will be added to your account. Checks that are returned as unpaid by your bank will result in a \$30.00 charge.

In regards to requests for responding to a subpoena and requests for records/summary of medical records, you agree to be responsible directly for these services.

If you are having financial difficulties that make payment difficult, please let me know. Sometimes money is one of the hardest things for a patient to discuss.

APPOINTMENTS. Appointments can be made by calling (214) 526-4525 Monday through Thursday between the hours of 09:00 AM and 5:00 PM. Fridays until 3:00 PM.

UNUSED APPOINTMENTS. Scheduled appointments are time held for you, and **you are responsible for payment for that time.** If you cancel a scheduled appointment with more than 24 hours' notice, you will not be charged for that time. If you cancel or miss a session with less notice, you will be charged unless I am able to fill the time with another patient. If, after discussion, it is clear that the reason for missing the appointment was entirely beyond your control, you may not be charged. Special conditions will be discussed if we consider making a commitment to very intensive psychotherapeutic treatment. Insurance companies or other third-party payers will not accept claims for unused appointments; therefore you will be responsible for unused appointments in full.

NOTICE OF PRIVACY AND CONFIDENTIALITY. Privacy and confidentiality is a cornerstone of psychiatric treatment. Discussions between a psychiatrist and client are confidential. No information will be released without the client's written consent unless mandated by law. Possible exceptions to confidentiality include but are not limited to the following situations: child abuse; abuse of the elderly or disabled; abuse of patients in mental health facilities; sexual exploitation; criminal prosecutions; child custody cases; suits in which the mental health of a party is in issue; fee disputes between the psychiatrist and the client; a negligence suit brought by the client against the psychiatrist; or the filing of a complaint with the state licensing board or other regulatory body. If you have any questions about confidentiality, you should bring them to my attention so that we can discuss the matter further. By signing this information and consent form, you are giving your consent to me to share confidential information with all persons mandated by law and with the agency that referred you and the managed care company and/or insurance carrier responsible for providing your mental health care services and payment for those services, and you are also releasing me and holding me harmless from any departure from the right of confidentiality that may result.

For all patients, I keep records describing the patient's clinical condition and treatment, but I avoid documenting potentially embarrassing personal information if I can do so in a manner consistent with medical responsibility. Psychotherapy notes will have a higher level of protection under the HIPAA (Health Insurance Portability and Accountability Act of 1996) privacy regulations that took effect in April 2003. Then their contents may not be divulged without your specific authorization, which is not permitted to be required as a condition of insurance coverage. (Other exceptions to the special protection of psychotherapy notes under law are to prevent harm to the patient or others, for the therapist's defense in legal actions, regulatory actions, regulatory oversight of the therapist's professional status, confidential supervision in training situations, or investigation by a medical examiner in the event of a patient's death.)

I serve as the Privacy Official and Contact Person as required by HIPAA. I keep both paper and electronic medical records. Paper records are locked at all times when the office is closed, and any electronic files are password protected to protect your information. You have the right to view your general medical record (but not psychotherapy notes) and request amendments within a reasonable period of time. Records will be retained at least as long as required by law. If you give consent for release of medical information from your general medical record, in compliance with HIPAA, I will disclose only the minimum amount of information necessary to serve the purpose for which the request has been made. The American Psychiatric Association has defined guidelines for minimum disclosure. Also under HIPAA regulations, I will provide you with a notice of privacy practices. I must ask you to sign a separate consent form and acknowledgement that I have given you this notice.

Under HIPAA your consent is not required for physicians to release information for treatment, payment, or healthcare operations. However, I have the right to offer you the opportunity to withhold consent for release of any or all information, with the understanding that if you withhold consent, it may not be possible for me to communicate with other doctors, laboratories, pharmacies, etc., or to submit insurance claims or give supporting clinical information without further action on your part to give consent. I believe that it is important for doctor-patient relationship to offer you the choice of giving or withholding consent, rather than assuming that you accede to the HIPAA regulation's automatic consent.

I will be very happy to discuss any part of this notice with you at your request at any time.

CONFIDENTIALITY AND THIRD PARTY PAYERS. You should realize that any information given at your request to an insurance company or managed care company is thereafter beyond my control. Health insurance companies sometimes give information to the Medical Information Bureau, which may affect your future eligibility for life, disability, or other insurance. Some employers obtain identifiable data from administrators of their health insurance. Medicare and other insurance plans have the right to inspect the medical records of subscribers who file claims. In my experience, such events are rare, and I would resist them to the greatest extent legally possible, but it is important that you know that this can happen if you choose to file claims for insurance or Medicare payments. However, the best safeguard for your privacy is not to involve third parties in your treatment. Other breaches of privacy could occur in extreme situations that are beyond my control, are required by law, or are essential to prevent imminent, serious harm.

DUTY TO WARN. In the event that I reasonably believe that you are a danger, physically or emotionally, to yourself or to another person, I will warn the person in danger and contact the following persons, in addition to medical and law enforcement personnel. By signing this consent form, you give your consent to make these contacts in these circumstances.

Name: _____ Telephone number: _____

Name: _____ Telephone number: _____

Name: _____ Telephone number: _____

CONTACTING THE CLIENT. I consent for the psychiatrist to communicate with me by mail and by phone at the following addresses and phone numbers, and I will IMMEDIATELY advise the psychiatrist in the event of any change:

Address: _____ Telephone number: _____

PSYCHIATRIST'S INCAPACITY OR DEATH. I acknowledge that, in the event the psychiatrist becomes incapacitated or dies, it will become necessary for another psychiatrist to take possession of my file and records. By signing this information and consent form, I give my consent to allowing another psychiatrist selected by the psychiatrist to take possession of my file and records and provide me with copies upon request, or to deliver them to a therapist of my choice.

INITIAL TREATMENT PLAN. By signing this information and consent form below, I agree to the initial treatment plan below. Usually the initial treatment plan begins only with a psychiatric evaluation, unless otherwise stated below.

CONSENT TO TREATMENT. I, voluntarily, agree to receive Mental Health assessment, care, treatment, or services, and authorize the undersigned psychiatrist to provide such care, treatment, or services as are considered necessary and advisable.

I understand and agree that I will participate in the planning of my care, treatment, or services, and that I may stop such care, treatment, or services that I receive through the undersigned therapist at any time.

By signing this Information and Consent form, I, the undersigned client, acknowledge that I have both read and understood all the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Signature

Date

Client (Printed Name)

As witnessed by:

Brian C. Forsythe, D.O.

Date