Lubbock Psychiatry, PLLC
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PATIENT CONSENT AGREEMENT AND POLICIES

I hereby give my consent and authorization to be evaluated and receive medical care from Lubbock Psychiatry, PLLC, and its employees, contractors, agents, and associates (collectively referred to as "Practice").

I further authorize Practice to access, order, and review any diagnostic testing Practice deem necessary or advisable for the medical evaluation and management of me as a patient of Practice.

I further authorize Practice to communicate with my other healthcare professionals and providers where Practice deems it advisable or necessary in providing care to me.

PAYMENT

I understand that payment in full is due at the time of service.

I understand that Practice does not at this time accept private insurance and that that I am personally responsible for the payment of all fees for services provided by Practice at the time the service is provided. I further understand and agree that if I fail to make payment when due and the account becomes delinquent it may be grounds for termination of care.

I understand that if I am covered under Medicare, I must notify Practice to complete a Medicare Opt Out agreement with the Practice.

TREATMENT PARTICIPATION

I understand that the physician-patient relationship is a voluntary relationship and that circumstances may arise where a patient chooses to end care with Practice, or Practice chooses to terminate care with a patient. In the event either party chooses to end the physician-patient relationship, Practice shall abide by requirements of the Texas Medical Board regarding termination of care of a patient.

POLICIES

Appointments

I understand that if I wish to reschedule or cancel my scheduled appointment, I must do so at least 24 hours prior to my scheduled appointment. Failure to do so or not showing up for the appointment will be subject to the full charge of the appointment.

I understand that patients can request appointments by telephone or through the patient portal. Dates will be confirmed ahead of time; however, it is the patient's or guardian's responsibility to keep track of the appointment to avoid charges for missed or canceled appointments.

I understand that if a patient arrives late to an appointment, it can be disruptive to other patients. The provider may cancel and reschedule the appointment if the patient is late to their appointment. The patient will be subject to the full charge of the appointment.

I understand that if I have not been seen by Practice for more than 12 months, I may not be considered a patient any longer.

I understand that after two consecutive missed appointments within one calendar year, the provider may dismiss a patient from Practice due to treatment noncompliance.

I understand that if the doctor must cancel an appointment, the patient will be advised in advance. Providers are only allowed to cancel appointments for patients on the same day due to a clinical or personal, unforeseen emergency.

Communication

I understand that regular brief phone calls made between the hours of 8:00 a.m. and 5:00 p.m. on weekdays will be returned as quickly as possible; calls left before 3:00 p.m. will typically be returned the same day, but this cannot be guaranteed. The Practice reserves the right to bill for phone calls or any time spent on clinical tasks.

I understand that treatment with us may involve undergoing evaluation, being prescribed medications, and/or engaging in various therapy treatments. If your treatment involves medication, your provider will explain the critical risks, benefits, and side effects to you. If unexpected side effects are experienced upon taking medications, please call the office during business hours. If outside of business hours, please call 911 or present to nearest emergency department immediately.

I understand that in case of emergency, including but not limited to, suicidal ideation, homicidal ideation, auditory or visual hallucinations, adverse or side effects from medications, or decompensation, I should call 911 and go to the nearest emergency room. I understand that

the practice does NOT routinely monitor phone or patient portal messages left after hours, on holidays, or on weekends and these should not be used in lieu of seeking emergency or urgent care.

I understand that all medications have inherent risk, and it is my responsibility to discuss any questions or concerns with my physician and pharmacist. I understand that antipsychotics have a risk of extrapyramidal symptoms and tardive dyskinesia. I understand that in case of pregnancy, there can be risks related to fertility, teratogenesis, and breastfeeding.

I understand it is my responsibility to have a primary care physician that I see for regular checkups, physicals, and annual bloodwork.

I understand that Practice utilizes a patient portal that you have the option of using. This is the only means by which we will receive electronic communications from our patients to ensure privacy compliance.

Medication Refills

I understand that refills should be requested via phone call to our office or via the patient portal. Please ensure that you call at least 72 business hours before your medication runs out. Prescriptions may only be refilled for current patients and those who maintain their regularly scheduled appointments.

Medication refills will NOT be performed in the following cases:

- After office hours (including possibly late Friday afternoon requests) or over the weekend
- During holidays
- For patients who repeatedly miss appointments
- If there is suspicion of misuse of medications or failure to comply with urine drug screen requirements

I understand that Practice will perform prior authorizations; however, it is essential to understand that these authorizations do take several days to be approved. Please contact your insurance as well if you know your services require prior approval.

Additional Requests

I understand that Practice providers do not testify in court, but if legal actions occur in which we are requested or subpoenaed to provide testimony you will be responsible for providing the following even if the subpoena is sent from the opposing side of the case and even if your ongoing relationship with the provider has ended:

- Travel expenses.
- Hourly or per diem fees based on the provider's then current session rates, plus 50% of that fee from the time the provider leaves his or her office until their return.

If the provider is needed to travel to an out of office consultation, charges are billed at 150% of the in-office fee and include travel time.

CONFIDENTIALITY

I understand that anything the patient reveals in a session is confidential and cannot be released to another person without your consent. Exceptions to this rule of confidentiality occur when the provider reasonably believes that there is imminent risk of harm to yourself or another person, if there is mandated reporting to CPS or APS, or if a judge requests information.

I understand that I further authorize Practice to communicate with my other healthcare professionals and providers where the practice deems it advisable or necessary in providing care to me.

COPIES OF MEDICAL RECORDS

I understand that Practice shall create and maintain a patient chart regarding my evaluation and that if I become a patient of Practice then this patient chart will become part of my ongoing patient record. I further understand that while I am permitted access to my medical records, that I will abide by the Practice policies for requesting copies of my records. In addition, I understand that as a mental health provider, Practice is subject to certain restrictions regarding the release of medical records to patients.

I understand that the duration of this consent is indefinite and continues until revoked in writing.

I acknowledge that I have read and understand the above Patient Consent Agreement and Policies, and that I agree to the terms therein.

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Patient Name

____ ______________________

Signature of patient/guardian/legal representative Signature date

____ ______________________

Signature of witness Signature date