**OFFICE POLICIES – PAYMENT INFORMATION CONSENT FORM**

**Please be advised that Dr. Rosen does not accept insurance and will not bill your insurance plan. Payment in full must be made at the time of service.**

**Payment Method:** This practice accepts cash, personal checks, and credit cards (Visa, Master Card and American Express.) Payment is expected at the time of service. You will be responsible for any fees associated with bounced or returned checks.

**Insurance Information:** You will be provided with a receipt at the time of payment. Contact your insurance company if you have any questions regarding your reimbursement, as each carrier differs.

**Cancellations or Broken Appointments:** Dr. Rosen has a 24-hour cancellation policy for appointments. Unless you cancel at least 24 hours before the appointment time, you will be charged for the visit at the regular rate.

**Contacting Dr. Rosen:**Dr. Rosen attempts to be accessible for all urgent issues. If she is not immediately available by office telephone, please leave a detailed voice message and she will return your call as soon as possible. Calls are generally returned within one business day. Please be judicious when calling Dr. Rosen after normal business hours.  If your call is an emergency, please contact 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments. Please also note that email should never be used for urgent or emergency issues. This is not a confidential means of communication and Dr. Rosen cannot ensure that email messages will be received or responded to in a timely fashion.

**Account Balances:** Payment is expected at the time of service. If the fees are not paid at the time of service, the open balance will be automatically charged to the credit card that you have provided on the Authorization for Credit Card Use form or the one verbally given at the initial intake appointment phone call. If, in any event there is a balance carryover beyond two sessions, further appointments will not be scheduled until the balance is paid in full.

**Records:** The practice uses electronic medical records and e-prescribing. This consent acknowledges your permission for their use. Records will not be released from the office without your explicit consent, and will only be released to the patient, parent/guardian or designated authorized party. Any requests for photocopies of records must be made in advance and there will be a charge per page for processing.

**Use of unencrypted email communication**

Communication over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via unencrypted email. Patients are discouraged from communicating with Dr. Rosen via email.

 **I have read and agreed to the above policies.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Guarantor (if the patient is under 18 years of age) Relationship Date

**AUTHORIZATION FOR CREDIT CARD USE**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Credit Card Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Expiration Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CVV \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Miri Rosen, MD requires that all accounts be paid in full at the time of service. If the fee is not paid when services are rendered it will automatically be charged to the card listed above or the one that was given at the time of booking the initial visit. By furnishing your credit card information at the initial intake and/or on this form, you are agreeing to this policy. I give authorization for Miri Rosen, MD to charge my credit card for all therapy, telephone sessions, reports, consulted medical advice, and medical management sessions that have open balances.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Date

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**CONSENT FOR TREATMENT**

I am an independently practicing professional. I am completely independent in providing you with clinical services and I alone am fully responsible for those services. My professional records are separately maintained and no one else can have access to them without your specific, written permission or proper legal compulsion.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services by Miri Rosen, M.D. These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.

2. Receive a copy of this consent.

3. Withdraw this consent at any time.

|  |  |
| --- | --- |
| Signature of Patient or Personal Representative: | Date: |
| Signature of Parent, Legal Guardian or Conservator | Date: |
| Signature of Witness (if appropriate): | Date: |

As a supplement to your in-office appointments, I am inviting you to use email to communicate with my practice. Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email will be accessed by Dr. Rosen and you may expect any required response within 72 business hours. If you do not receive a response within that time frame, please call Dr. Rosen.

Email may be used for:

* Prescription refill requests
* Appointment requests
* Other matters not requiring an immediate response

Email should NEVER be used:

* In an emergency
* If you are experiencing any desire to harm yourself or others
* If you are experiencing a severe medication reaction
* If you need an immediate response
* To replace an in-person appointment

Risks of communicating via email include but are not limited to:

* Email may be seen by unintended viewers if addressed incorrectly.
* Someone posing as you could access your information.
* There is a risk that emails may not be received by either party in a timely matter as it may be caught by junk/spam filters.
* Emails are discoverable in litigation and may be used as evidence in court.
* There may be an unanticipated time delay between messages being sent and received

CONSENT TO EMAIL USE

By signing below, I consent to the use of email communication between myself and Dr. Rosen. I recognize that there are risks to its use, and despite Dr. Rosen’s best efforts, she cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in the form. I further agree to follow these policies and agree that should I fail to do so, Dr. Rosen may cease to allow me to use email to communicate with her. I also understand that I may withdraw my consent to communicate via email at any time by notifying Dr. Rosen in writing.

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Patient/Patient Representative Name Signature Date

**CONSENT FOR TELEPSYCHIATRY TREATMENT**

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Google Meet, in which the psychiatrist and the patient are not at the same location. Benefits include that telepsychiatry will allow the patient to receive medical care without the need to visit the office and travel long distances. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video), delays in medical evaluation and treatment due to deficiencies or failures of the equipment, and security protocols can fail and cause a breach of privacy. Alternatives to telepsychiatry include traditional face to face sessions.

Your Rights:

1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.

2) I understand that Google Meet is a HIPAA compliant platform that includes protocols to safeguard the data and to aid in protecting against intentional or unintentional corruption.

3) I have the right to withdraw my consent to the use of telepsychiatry during the course of my care at any time.

4) I understand that Dr. Rosen has the right to withhold or withdraw consent for the use of telepsychiatry during the course of my care at any time.

5) I understand that all rules and regulations which apply to the practice of medicine in the State of New York also apply to telepsychiatry.

Your Responsibilities:

1) I will not record any telepsychiatry sessions without the prior written consent of Dr. Rosen and I understand that Dr. Rosen will not record telepsychiatry sessions without my consent.

2) I will inform Dr. Rosen if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Rosen will inform me if any other person can hear or see any part of the session before the session begins.

3) I understand that I MUST be a resident of New York State to be eligible for telepsychiatry services from Dr. Rosen

4) I understand that I MUST be physically located in the state of New York during the telepsychiatry session unless previously arranged.

5) In the event of technology failure, I will follow contingency plan to call by phone to reschedule or complete treatment session.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. Miri Rosen to use telepsychiatry in the course of diagnosis and treatment.

|  |  |
| --- | --- |
| Signature of Patient or Personal Representative: | Date: |