Homeostasis

Integrative Mental Health

Office Policies

Name: _____ Date of Birth: _____ Age: _____

Home Phone: _____ Work: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Social Security Number: _____

Name of Spouse/Parent (if a minor): _____

Emergency Contact: Name: _____ Phone: _____

Primary Care Provider: _____

How did you find out about our practice?

Internet (which site): _____

Medical Practitioner Referral (who?): _____

Other (please specify): _____

Scope of Practice:

Homeostasis focuses on the treatment of complex conditions which include psychiatric disorders. The treatment of such disorders is multifaceted and as such, necessitates that you participate in any number of approaches. These may include but are not limited to: medications, counseling, psychological evaluation, nutritional therapy, and support groups. The frequency of your visits is clinically determined and may initially require that you be seen in the office several times per week. Inna Zelikman, PMH-NP has a collaborating physician, Howard Kornfeld M.D.

Initial: _____

Confidentiality Policy:

All information disclosed within sessions is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. However, this Agreement will constitute a release of medical information to associates and staff within the practice.

Initial: _____

Please indicate below whether if you would like our practitioners and staff to communicate with you regarding billing or health information via e-mail. Please note that communication via email is not necessarily secure. Although every effort is made to maintain confidentiality, inclusion of private health information via email is done at your own risk.

- I consent to email communication from practitioners and staff.

- I do not consent to email communication from practitioners and staff.

Initial: _____

Office Procedures:

The office staff attempts to answer phone calls between 9 am to 5 pm, Monday through Wednesday and 11am-7pm on Thursday. We are closed on Fridays. We are a small staff and have a limited capacity to respond to your needs over the telephone. Unless you have an urgent situation, we encourage you to make an appointment rather than use the phone to address your health needs.

Initial: _____

All after hour or other urgent phone calls should go through our answering service at 925-975-3112, that will page the on-call provider. For emergencies, call 911.

Initial: _____

Receiving psychoactive medications from providers outside of this office or increasing the dosage or frequency of your medications without prior approval may be grounds for termination of care from this office.

Initial: _____

Service Rates:

Inna Zelikman, N.P. $280.00 per hour

Other providers:
Howard Kornfeld, MD, addiction or pain consultation $380.00 per hour
Janis Phelps, MFT, Ph.D., clinical psychology: $180.00 per hour

Cancellation Policy:

Cancellations must be made within 48 hours of your appointment or you will be charged the full rate of your scheduled visit. Monday appointments must be cancelled on Thursday as the office is closed on Fridays.

Initial: _____

Administrative Service & Telephone Charges:

All activities requiring practitioner time outside of regular office visits including phone calls to the patient and/or calls on the patient's behalf, records review, document or letter preparation, travel time, and research, are billed based on the practitioner's hourly fee pro-rated to the nearest tenth of an hour. For example, based on Inna's hourly rate, every 6 minutes (tenth of an hour) is equivalent to $28.

Initial: _____

Insurance Reimbursement:

Clients who carry insurance should remember that professional services are charged to the patient and not to their insurance company. Upon request, staff will supply you with the necessary documents to submit to your insurance company for reimbursement.

Initial: _____

If you would like to submit the cost of your visits to your insurance company for reimbursement, a diagnosis code is required. These diagnosis codes may indicate mental health diagnoses. Due to the sensitive nature of this information, please consider whether or not you would like us to include diagnosis codes on your bills.

Please choose one of the two options below:

- Include diagnosis codes on my invoices.
- Do not include diagnosis codes on my invoices.

Initial: _____

Medication prior authorization attempts completed by our office are time consuming and may be non-productive. Administrative work by practitioners and office staff spent on prior authorizations will be billed at the practitioner's regular hourly rate. Please consider this when requesting our office to spend time on this process.

Initial: _____

Howard Kornfeld, M.D. and Associates has withdrawn from the Medicare program and is excluded from participation under Section 1128 of the Social Security Act. Therefore, services rendered by our office will be paid privately by the patient. By initialing below, you agree that this constitutes as a private contract to bill outside Medicare program.

Initial: _____

Refills, Laboratory Services:

All medication refills are best taken care of during your appointment time. If they are not, we require 48 hours' notice to refill medications. You will be billed at practitioners' hourly rate for time spent on refill requests.

Initial: _____

Lost or stolen prescriptions will require a police report and may not be replaced.

Initial: _____

Method of Payment:

Payment is accepted by credit card only, unless other arrangements have been made. By signing below, you are giving our office permission to charge the credit card listed for all services rendered.

Although we are not a covered entity under HIPAA, we do maintain strict confidentiality of medical information in accordance to state and federal law and to the same standards as HIPAA. If you request a chargeback from your credit card company after receiving services, your signature below also indicates your consent for us to provide medical information when necessary to the company in a confidential manner.

Name on Credit Card: _____

Card Number: _____

Expiration Date: ____/____ Card Security Code: _____

Credit Card Billing Address: _____

City: _____ State: _____ Zip Code: _____

Patient Signature: _____

Date: _____

Please note and understand that the terms and conditions of treatment will apply to any family members, friends, or health care professionals that with your authorization may need to be contacted to better coordinate your care.

Any time spent corresponding with such individuals (including telephone and electronic communication) is billable to you at the rates outlined above.

If you have any questions, please do not hesitate to ask. It is a privilege to assist you in your health improvement efforts. We understand that these health issues often require a significant amount of time, effort, patience, and honest communication. The end result is the integration of body, mind, and spirit. We look forward to assisting you in this process.

By signing this form, I consent to the above terms and conditions of treatment and acknowledge that I have read and fully understand the contents of this document. I recognize that I have received a copy of these policies for my future reference.

Patient Signature: _____

Date: _____