FACE SHEET

CLIENT INFORMATION:

Last Name_____ First Name_____ M.I_____

Date of Birth_____ Marital Status_____ Gender_____ Race_____

SS#_____ DL/ID#_____ Home #_____

Cell # _____ Work # _____

Mailing Address_____

City_____ State_____ Zip_____ Occupation_____

Email_____

INSURANCE INFORMATION: (Please provide cards so we may obtain for our records)

Primary Insurance_____ Policy #_____

Group #_____Insured Name on Card_____

Insured Date of Birth_____ Insured SS#_____

Secondary Insurance_____ Policy #_____

RESPONSIBLE PARTY INFORMATION: (If other than client)

Responsible Party Name_____ Relationship_____

DOB_____ SS#_____ Employer_____

Mailing Address (if different from above) _____

Home # _____Cell # _____ Work # _____

MEDICAL INFORMATION:

Physician's Office_____ Physician's Name_____

Phone #_____ ALLERGIES_____

Medical Conditions_____

Current Medications_____

Are you currently receiving disability? Yes or No Are you currently seeking disability? Yes or No

EMERGENCY CONTACT:

Contact Name_____ Phone # _____

Client/Parent/Guardian Signature_____ Date_____

CLIENT FINANCIAL POLICY

Welcome to Our Office! We welcome you to our office and appreciate the opportunity to provide you with our excellent services. We strive to provide the highest quality services to our patients with compassion and integrity. We believe understanding our financial policies is an essential element of your care and treatment.

Please read carefully and initial where requested indicating your understanding and acceptance of our policies and procedures.

We make every effort to keep down the cost of your medical care. It is our policy to ask for payment at the time of your visit. For your convenience, we accept Cash, Checks payable to Don A. DuBose M.D., Debit and Credit Cards. As a convenience to all our patients, we also offer easy-pay. It's a program where we simply maintain your credit, debit or check card information on file to capture any co-pay, deductibles or balances not covered by insurance.

_____ **Regarding Insurance**

(Initial here)

We participate with most major insurance carriers including Blue Cross Blue Shield, Tricare, and Medicare. As required by most insurance carriers, you are responsible for the payment of deductibles, co-payments and any non-covered services at the time of your office visits. By providing your insurance information, you have asked, and promised to pay for the services we provide you. If we are out of network with your insurance company, you will be made aware prior to signing up for services. At that time, if you decide to continue with treatment, you will be responsible for the full cost of services.

Please realize that:

1. Your insurance is a contract between you, your employer, and the insurance company and we are not a party to that contract.
2. Not all services are covered by all insurance policies. Some companies select certain services that they will not cover.

3. The "Usual and Customary Charges" that may be quoted by your insurance company are charges that have been determined and set by your insurance company. They do not necessarily reflect our fees.
4. **Please note:** Insurance will not pay for missed appointments or cancellations. A late cancellation is considered when it is cancelled within 24 hours of the appointment. If you cancel late or miss an appointment you will be responsible for the entire session fee, not just the amount of your co-pay.

Please know *your* benefits, limitations, and responsibilities of your plan. Federal laws prohibit us from changing your procedure and/or diagnosis codes just to get your claim paid. We make every effort to code and file claims accurately according to the services rendered and your physician's documentation. Annually, or whenever there are insurance changes, you are required to complete and update our insurance information form. You will be responsible for the fee of a service that was not covered by your insurance due to a change that we were unaware of.

I authorize payment of medical benefits to Future Psych Solutions, LLC, and/or physician for services rendered.

Signed: _____ Date: _____

I authorize the release of any medical or other information necessary to process claims for services rendered.

Signed: _____ Date: _____

_____ (Initial here) **TMS Policy and Payments**

Our policy for clients participating in TMS services is Co-payments and/or Co-insurances are due at the beginning of the week on a weekly basis. This policy also applies for Self-pay/no insurance coverage clients. For Example: If you start services on Monday, then on Monday prior to your treatment you will need to pay your co-pay and/or co-insurance for your treatments you will have Monday through Friday of that week. For your convenience, we also allow bi-weekly payments or full payments prior to rendering services.

_____ (Initial here) **No Insurance/Self Pay Policy**

We ask for payment in full **prior** to service.

_____ (Initial here) **Over Due Payments**

Payments are due at the time of service. A billing fee of $5.00 will be added to your account each time we have to send you a bill (Notices are sent out once a month). If we have not received payment from your insurance after 30 days, we will contact you for assistance and/or to make payment arrangements.

We do realize that there are times that a temporary financial problem may affect your payment of your account. In that case, PLEASE, contact our practice manager for assistance so that we may be able to set up payment options for you.

_____ (Initial here) **Cancelled and Missed Appointments**

In order to provide the best possible service and availability to ALL of our clients, we reserve the right to charge the full session fee for any appointments not canceled at least 24 hours in advance, regardless of the reason for the cancellation/missed visit. ***We will immediately charge the credit card on file in the amount of $99.00 for any late cancelations or no shows that were not canceled in advance.*** ** There will be a fee of $75.00 for any prescriptions that need to be fill due to the late cancellation or no show appointment. Please call us as early as possible if you will need to reschedule your appointment. ***Monday appointments must be cancelled by 9:30 a.m. the previous Friday to avoid a late cancellation charge.***

_____ (Initial here) **WE REQUIRE EVERY PATIENT TO KEEP A CREDIT CARD ON FILE. UPON LATE CANCELLATION OR NO-SHOW, THIS CARD WILL BE CHARGED. THIS IS A REQUIREMENT TO BE A PATIENT IN OUR PRACTICE.**

_____ (Initial here) **Other Financial Guidelines**

Clients who use a third party payer such as a non-client responsible party, family trust or financial account, public assistance or any other payer for the payment of our charges, must coordinate with your third party payer to provide payment at the time of your appointment. A receipt will be provided.

All checks returned for non-sufficient funds or otherwise not paid will be subject to a $35.00 fee plus the amount of the check.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time to time by the practice.

_____ _____

Patient/Responsible Party Signature

_____ **Date**

The majority of this document is mandated by both South Carolina State law and Public Law 104-91; it is provided for your protection. Future Psych Solutions, LLC has tried to anticipate the risks you may face as a result of seeking care. If you have any questions regarding any documents you have received, please feel free to discuss them with Stewart Courtney, Chief Operations Officer of Future Psych Solutions.

Contact Information: Future Psych Solutions is located at 1911 Gadsden St., Suite 101, Columbia, SC 29201. Our office hours are Monday through Friday 9:00 a.m. - 5:00 p.m. Our clients are seen by appointment only and special appointments for evenings, weekends, and other selected times can be considered. Our telephone number is 803-851-0642 and our fax number is 844-617-1550. Our email address is info@futurepsychsolutions.com . We do our best to respond back within 24 – 48 hours. Our practice manager is Stewart Courtney. He is available for any questions or concerns that you may have. Please do not hesitate to let the office staff know that you would like to speak with the practice manager.

Personal Qualifications: Don A. DuBose, M.D. is the owner CEO & medical director. He practices as an interventional psychiatrist. Dr. DuBose is trained to see children and adults for psychiatry services.

Services: Dr. DuBose provides a number of services in the area of professional counseling which include:

- Psychiatric diagnosis
- Evaluations and treatment for depression and ADHD (specifically for TMS)
- Collaboration with other therapists and case managers
- Laboratory monitoring genetic testing
- Exercise therapy
- Nutritional counseling
- Telemedicine
- Ketamine Infusion for depression

TMS Services: Future Psych Solutions would like to emphasis the importance of being consistent with TMS treatment. This treatment needs to be done 5 days a week for an average of 6 weeks then taper visits for the next 3 weeks. Cancelling, missing appointments, and/or rescheduling will decrease the chances of effectiveness of the TMS treatment.

Fees: It is customary to pay for professional services at the time they are rendered. Future Psych Solutions, charges the following fees for the following services. TMS fees are $150.00 for the TMS consultation, $375.00 for the motor threshold determination visit then $325 for each treatment after the initial which can range from 35 to 40 treatments.

Confidentiality: The information you share during your session is protected health information and is generally considered confidential by both South Carolina statute law and federal regulations. Your patient file can be subpoenaed in South Carolina through a court order (signed only by a judge) but is considered privileged in the federal court system. Dr. Don A. DuBose is mandated by state and federal regulations-through duties to warn-to breach confidentiality if he discovers: 1.) you are threatening self-harm of suicide; 2.) you are threatening to harm another or homicide; 3.) a child has been or is being abused or neglected; 4.) a vulnerable adult has been or is being abused or neglected and/or 5.) you have broken or intend to break a law or laws. Finally, if you wish your protected health information released to

someone else (e.g. an attorney, a physician, another mental health agency, etc.), you must sign a specific Release of Information.

Future Psych Solutions. Holds the right to not release session notes because Future Psych Solutions is considered a "covered entity" under Public Law 104-191, commonly known as the Health Insurance Portability and Accountability Act (HIPAA) passed August 8, 1996. Under this law, treatment notes are afforded special privacy protection.

If other information is required by your insurance, which is infrequent, Future Psych Solutions will only do so after obtaining your consent. Confidentiality must also be broken if a government court orders the information.

Ethics: All Provider follows the Code of Ethics of the following organization:

- The South Carolina Board of Medical Examiners, which is a division of the South Carolina Board of Labor, Licensing, and Regulation.

Informed Consent: You will be asked to sign the last page of this document. Your signature verifies you have been given this document and the HIPAA document; that you have read and understand these documents, and that you consent to treatment. Further you need to be aware:

- Treatment isn't always successful and may open unexpected emotionally sensitive areas.
- Dr. Don A. DuBose may need to consult with your physician, attorney or other counselor.
- Dr. Don A. DuBose is licensed through the SC Board of Medical Examiners.
- The Practice Manager for Future Psych Solutions is Stewart Courtney. He is a confidential administrator under state and federal law. He will be your major contact for appointments, problems, complaints, and accommodations.

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This document may be updated without notice so please review it each time you visit us. A copy of this statement is always available upon request.

All information revealed by you in a session and most information placed in your file (all medical records or other individually identifiable health information held or disclosed in any form [electronic, paper, or oral]) is considered "protected health information" by HIPAA. As such, your protected health information ***cannot be distributed to anyone else without your express informed and voluntary written consent or authorization*.** The exceptions to this are defined immediately below. Additional information regarding your rights as a client can be found in your physician's Professional Disclosure Statement and Consent for Treatment.

Use or disclosure of the following protected health information

<u>does not require</u> your consent of authorization:

1. Uses and disclosures required by law-*like files court-ordered by a Judge*

1. Uses and disclosures about victims of abuse, neglect, or domestic violence-*like the duties to warn explained in your therapist's/counselor's Disclosure Statement*

1. Uses and disclosures for health and oversight activities-*like correcting records or correcting records already disclosed*

1. Uses and disclosures for judicial and administrative proceedings-*like a case where you are claiming malpractice or breech of ethics*

1. Uses and disclosures of law enforcement purposes-*like if you intend to harm someone else (see Duties to Warn in your therapists/counselor's Disclosure Statement)*

1. Uses and disclosures for research purposes-*like using client information in research; always maintaining client confidentiality*

1. Uses and disclosures to avert a serious threat to health or safety-*like calling Probate Court for a commitment hearing*

1. Uses and disclosures for Worker's Compensation-*like the basic information obtained in session as a result of your Worker's Compensation claim*

<u>Your Rights as a Client/Patient under HIPAA</u>

1.

- As a client, you have the right to see your patient file, unless it would endanger your health or another person's health or safety. *Session notes are afforded special privacy protection under HIPAA regulations and are excluded from this right*

1.

- As a client you may obtain a copy of your treatment with Don A. DuBose, M.D, or a summary of your treatment. There is a standard administrative fee for copies and Don A. DuBose, M.D may charge a fee for a treatment summary.
- As a client you have the right to request amendments to your patient file.

1.

- As a client you have the right to receive a history of all disclosures of protected health information. You will be required to pay any copying fees at $.20 a page plus a $15 service fee.

1.

- As a client you have the right to restrict the use and disclosure of your protected health information for the purpose of treatment, payment, and operations. If you choose to

release any protected health information, you will be required to sign a Release of Information form detailing exactly to whom and what information you wish disclosed.

1.

- As a client you have the right to register a complaint with the Secretary of Health and Human Services if you feel your rights, herein explained, have been violated.

If, at any point, you would like a copy of this document for your records, please inform the office staff of this request.

Important Disclosure Regarding Paperwork Filled Out By Providers

PLEASE NOTE: We are **NOT** required to fill out any paperwork at our office, regardless of the nature of the paperwork. You can make the request and it will be up to the provider if this accommodation will be made. If the provider makes this accommodation, there will be a minimum fee of **$20.00 per page,** no exceptions. In order for any paperwork to be filled out, a patient must see the provider for at least 4 visits prior to the request. Please understand that this does not include the office staff/providers printing off medical notes for your records. Medical notes can be printed off for your record at no charge.

*****Please allow up to 3 weeks for any requests for paperwork or medical notes to be completed.**

_____

(Initial Here)

Important Note About The Role Of Our Medical Director

Dear Patient,

Don A. DuBose, MD is the medical director of this practice. He oversees and supervises all cases and client interactions at this practice. He communicates with all psychiatrists, therapists, physicians' assistants, and nurse practitioners about each patient.

_____

(Initial Here)

Thank You!

I acknowledge that I have received and read the ***Future Psych Solutions Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights.*** I further acknowledge that I seek and consent to treatment at Future Psych Solutions, LLC. with Dr. Don A. DuBose. My signature below confirms that I understand and accept all the information contained in the ***Future Psych Solutions Professional Disclosure Statement and Consent for Treatment*** and the ***HIPAA Client's Rights.***

_____

Printed Client's name

_____

Signature of Client

_____

Date