ROCHESTER CENTER
FOR BEHAVIORAL MEDICINE

RCBM Policies and Procedures

Welcome to the Rochester Center for Behavioral Medicine. We are pleased that you have chosen to receive treatment at our clinic. It is our goal to help expedite your treatment goals as smoothly as possible. For this reason, there are several policies of which you should become aware. Please review the following:

Prescription Policies:
You may obtain prescription refills from your prescribing clinician during your scheduled appointments. If your prescriptions will run out before your next appointment, you may submit our online refill request form, which can be found on our website (www.rcbm.net) under "Prescription Refills." Please note that medication changes can only be made by your prescriber, not by RCBM office staff.

Be sure to allow 2 BUSINESS DAYS for your prescription to be processed. Please be aware that the prescription request system is not checked over the weekend, so requests submitted from Friday afternoon through Sunday night may not be received until Monday morning.

We are now able to e-scribe controlled substance prescriptions to *most* pharmacies. This newer (2015) functionality is a safer and more efficient way to prescribe these medications. If your pharmacy does not participate in this program, we may ask you to select a pharmacy that does. Please allow us time to transmit your prescriptions to your pharmacy after your appointment.

Some insurance companies may require a prior authorization before certain prescriptions can be filled. This process often takes up to an hour of administrative time. Please note that, if a prior authorization is needed, you may need to wait one to three days for your prescription to be authorized by your insurance company.

Medications prescribed by RCBM are expected to be taken only as prescribed, and only by the patient to whom they were issued. Any misuse or diversion of medications may result in termination of care.

Appointment Duration and Frequency:
Once you are doing well on your medication regimen, your medication management visits may become less frequent. However, the maximum time between appointments cannot exceed four months unless your clinician has made a special exception for you. Further, three-month prescriptions cannot be processed until outstanding balances have been addressed.

The frequency of therapy visits varies based on acuity of the patient's presenting concerns. Therapy visits are generally 45-50 minutes in length. Medication reviews and supportive therapy typically last around 15-20 minutes. Therapy visits longer than 53 minutes are considered 'extended visits' and may be billed at a proportionate rate.

Cancellation Policy:
We ask that you provide at least 24 hours of notice if you need to cancel your appointment (48 hours for testing appointments), as we often have a wait list that we try to accommodate. A message may be left if you call before or after business hours. If you do not give the required notice on a missed appointment, you are subject to a charge that is the full amount of your visit. Please let your clinician know if there has been an emergency. This missed appointment fee <u>cannot be billed to your insurance company</u>.

Reminder Calls/ Phone Tree:
Appointment reminders are made the business day before your appointment. Our reminder system allows you to receive a reminder by any combination of e-mail, text, or phone call. You may use this system to confirm appointments but cancellations must be made by calling our office directly. You are able to opt out of any of these automated reminder methods at any time. Be sure you have provided the front office staff with any changes in your contact information to ensure that you receive these reminders. Please be aware that reminder calls are offered as a *courtesy* and are not guaranteed. The patient remains responsible for keeping track of your appointment date and time.

Updating Information:
Please be sure to notify us of any changes to your contact information, including the best phone number to use for reminder calls. Also remember to give us your updated insurance card should your policy change. If an up-to-date insurance card is not provided, you will be responsible for out-of-pocket payment for the visit.

Electronic Medical Record:
The Rochester Center for Behavioral Medicine utilizes an Electronic Medical Record. All information contained in your record is securely stored and remotely backed up, and all Electronic Protected Health Information (ePHI) policies are carefully observed.
You may notice your clinician typing throughout your visit. This allows our staff to accurately capture the information you are presenting.

HIPAA Information:
RCBM takes privacy very seriously. We require all employees to complete a formal HIPAA training course and pass a certification exam. RCBM staff exercises absolute discretion when conducting transactions involving the exchange of protected health information (PHI). We will not release any PHI to an outside source unless we have obtained the patient's (or patient's legal guardian's) written consent. If you need any information released, your clinician or our front office staff would be happy to provide you with the appropriate forms. The forms can also be located on our website. Please note that, upon the request of your referring physician's office, we may release information required to coordinate your care, as allowed by HIPAA.

Medical Record Requests:
Should you wish, we are happy to release information to other medical professionals. To make a medical records request, please call extension 259. Once the request has been made and a release has been signed, it may take up to two weeks to process your request. Depending on the nature of your request, you may incur a fee for this service. Please be aware that progress notes are kept for internal use. Therefore, it is up to the discretion of the clinician to decide whether records will be released directly to the patient.

Payment:
Please be prepared to pay your co-pay or session fee at the time of service. You are responsible for your insurance company's "allowed amount" for each visit until your deductible has been met. Payment is expected on the date of service even when the responsible party is not present for the visit.

Should you need your clinician to prepare a letter, report, or complete forms on your behalf, you may incur a charge for time spent on these activities. This charge is typically billed at $25 for every 15 minutes spent. Please note that this charge is not billable to insurance.

RCBM accept checks, cash, Visa, MasterCard and American Express. If you cannot make a payment on the date of service, please contact our biller, Brenda, at (248) 851-0526 to make payment arrangements. Should you wish, we are able to leave a credit card on file. Individuals who default on established payment plans without contacting our billing office, or individuals who do not return phone calls related to billing issues, may be asked to seek care elsewhere.

Insurance Questions:
We understand that insurance issues can be difficult to navigate. Terms such as deductible, co-insurance, co-pay, and out-of-pocket-maximum, may not be universally understood. If you have any questions about general insurance terms or need help understanding your specific coverage, please feel free to contact our insurance liaison, Ali, at (248) 608-8800.

Mid-Level Providers:
The Rochester Center employs physician assistants and psychiatric nurse practitioners (often referred to as mid-level providers or physician extenders). These professionals are experienced, independently licensed behavioral health providers. They are able to prescribe medications and practice under the close supervision of Joel L. Young, M.D., Medical Director. Patients may be directly assigned to the care of these providers or may see a mid-level provider if Dr. Young becomes unexpectedly unavailable.

Useful Information:
RCBM is active on social media. Please follow us on Facebook (RCBM) and Twitter (@RochesterCenter) to stay abreast of mental health news, topics of interest, and clinic news and updates. We also update our website (www.rcbm.net) regularly. Finally, Dr. Young's blog on PsychologyToday.com (When Your Adult Child Breaks Your Heart) is an excellent source of information on all topics related to mental health.

Please feel free to speak with our front office staff if you need clarification on any of the information listed above. Thank you for your cooperation. We look forward to working with you!

_____

I have read the above-listed policies and agree to abide by them. I understand that any violation of these policies may result in the termination of my care.

_____ _____

Patient/Guardian Signature *Date*

ROCHESTER CENTER FOR BEHAVIORAL MEDICINE (RCBM)
DOCUMENTATION OF GOOD FAITH EFFORT / ACKNOWLEDGEMENT OF THE HIPAA PRIVACY NOTICE

Patient Name (please print): _____

Patient Signature: _____ Date: _____

The patient presented for treatment on this date and was provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:

_____

_____

☐ There was a medical emergency. (The practice will attempt to obtain acknowledgement at the next available opportunity.)

☐ Other reason, as described below:

_____

_____ _____

_____

_____ _____

_____ _____

Signature of employee completing form:_____

Payment Policy

Thank you for choosing the Rochester Center for Behavioral Medicine. We are committed to providing you with the best in quality health care. We have outlined our payment policies for you below. Please read carefully and feel free to ask us any questions you may have. A copy will be provided to you upon request.

1. Insurance. We participate with many insurance plans. If you are insured by a plan with which we do not participate, payment in full is expected at each visit. If you are insured by a plan with which we DO participate with but have not presented us with an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have. By signing you are authorizing RCBM to release required information to your insurance company.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Non-payment at the time of service may result in a service charge.

3. Non-covered services. Please be aware that some – perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

4. Proof of Insurance. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. Coverage changes. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. Please be aware that if a balance remains unpaid for more than 90 days, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice.

8. Missed appointments. If you must cancel an appointment, we ask that you give the office at least 24 hours notice, 48 hours notice is required for screening/testing appointments. Otherwise, you may be charged the full session fee, without insurance reflecting. This charge will be your responsibility and cannot be billed to insurance.

9. Divorce/Separation. In situations of divorce or separation, the person bringing the minor child to treatment will be responsible for payment on the date of service. If the divorce decree requires that other (non-present) parent to pay all or part of the treatment cost, it is the present parent's responsibility to collect from the other parent. For adults, the person seeking treatment is the person responsible for payment.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

***I have read and understand the payment policy and agree to abide by its guidelines**:*

_____ _____

Signature of patient or responsible party **Date**

_____

Please print name of person signed above

10/7/2016

ROCHESTER CENTER FOR BEHAVIORAL MEDICINE

CONFIDENTIAL ADULT HISTORY

Name:_____ ☐ Male ☐ Female Date of Appointment:_____

Date of Birth:_____ Age:_____ Natural ☐ Adopted ☐

Current Address: _____

Place of Birth _____ Religion: _____

Marital Status:
Single ☐ Married ☐ Divorce ☐ Remarried ☐ Widowed ☐ Significant Relationship ☐ Life Partner ☐

If you have a spouse/partner, please list the following: their name, age, years together:

_____

If previously married, please provide the years of marriage (s), divorce (s), and spousal death, etc.:

_____

Presenting Concerns—Please check all that apply:

☐ ADD/ADHD	☐ Anxiety	☐ Bipolar Disorder	☐ Chronic Pain
☐ Depression	☐ Fatigue	☐ Psychosis	☐ Behavioral Issues
☐ Sleep Disorder	☐ Substance Use	☐ Trauma	☐ Academic Issues

Other: _____

Please explain why you are seeking professional assistance:

_____

_____

_____

EDUCATIONAL BACKGROUND:

Highest Grade / Degree Completed: _____
Special Training / Skills: _____
Occupation:_____ Employer:_____
Military History: Yes ☐ No ☐ Branch of service, location & years:_____

FAMILY HISTORY:

Family Members	Living "L"	Deceased "D"	Lives with you? "Yes" or "No"	Age	Quality of the Relationship
Mother:					
Father:					
Step-Mother:					
Step-Father:					
Siblings:					
Grandparents:					
Others (Specify):					

Does any family member have a history of emotional or substance abuse problems and/or treatments?
Yes ☐ No ☐
If yes, please provide details_____
_____
_____

CHILDREN:

Name:	Age:	Natural/Step/Adopted:	Lives with You? (Yes or No):
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____
_____	____	_____	_____

Have you ever experienced any academic or behavioral difficulties any time in school? Yes ☐ No ☐
If yes, please describe your difficulties:_____
_____

Have you ever been in trouble with the law? Yes ☐ No ☐
If yes, please detail the circumstances: _____
_____

SLEEPING DIFFICULTIES:

	Additional information:
☐ Difficulty with daily functioning	
☐ Falling asleep	
☐ Falling back to sleep	
☐ Tired upon waking	
☐ Early morning awakening	
☐	
☐ Nightmares	
☐	
☐	
☐ Snoring	
☐ Stop breathing during sleep	
☐	

SUBSTANCE USE HISTORY:

ALCOHOL USE: Do you drink? Yes ☐ No ☐ If yes, what is your average daily consumption?
1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Other ☐ _____

Were you ever told or felt that you should cut down on drinking?
Yes ☐ No ☐

Have you ever felt bad about your drinking? Yes ☐ No ☐ If so, why?_____

Do you ever drink first thing in morning to steady your nerves or get rid of a hangover (an eye-opener)? Yes ☐ No ☐

DRUG USE: Do you use illegal drugs? Yes ☐ No ☐
Details_____

Drugs used: Marijuana ☐ Cocaine/Crack ☐ Amphetamines ☐ Heroin/Opiates ☐ PCP ☐

Barbiturates/Sedatives ☐ Over the counter ☐ Spice/K2 ☐ Other:_____

CAFFEINE USE (if any) – Number of Cups per Day: Are you sensitive to caffeine? ☐ Yes ☐ No
Coffee: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐
Tea: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐
Soda: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐

SMOKING STATUS:
Please check below the response that best summarizes your CIGARETTE smoking status and answer any questions corresponding to that response. Please note that 1 pack = 20 cigarettes.

☐ **Never** smoked.

☐ **Former** smoker: (*average* number of cigarettes patient used to smoke per day):
☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ 2 packs
☐ Other (include approximate amount patient used to smoke per day):_____

☐ **Current** smoker: (*average* number of cigarettes you currently smokes per day):
☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ 2 packs
☐ Other (include approximate amount patient used to smoke per day):_____

Total number of years that you have smoked-- these years do not need to be consecutive: _____

PAST TREATMENT HISTORY:
Please list all prior mental health and alcohol/substance abuse treatments that you have received. ☐ NONE
Where:_____ When:___ _____
Where:_____ When:___ _____
Where:_____ When:___ _____

HEALTH HISTORY:

MEDICAL PROBLEMS: Yes ☐ No ☐

Past	Present
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: Yes ☐ No ☐

Please list allergies	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

SURGICAL HISTORY: ☐ NONE

Surgery/Procedure:	**Date (Approximately):**

RECENT STRESSFUL LIFE EVENTS (within the past 2 years):

	Additional information:
☐ Marriage	
☐ Engagement	
☐ Separation	
☐ Divorce	
☐ Serious argument (s)	
☐ Break-up of serious relationship	
☐ Death of spouse	
☐ Child left home	
☐ Health (or behavior) of family member	
☐ Difficulty with a family member	
☐ Personal injury or illness	
☐ Sexual difficulty	
☐ Difficulties, changes at school or work	
☐ Retirement or loss of job	
☐ Changed residency	
☐ Legal difficulties, multiple traffic tickets, etc.	
☐ Financial difficulties	

SUICIDAL ISSUES

Have you ever thought about suicide? ☐ Yes ☐ No
If "Yes," please explain when and the circumstances" _____

_____

_____

Do you have a history of suicide attempts? Please explain "when" and "how": ☐ No Attempts

_____

_____

_____

Do you currently feel suicidal? ☐ Yes ☐ No

MEDICATION INFORMATION:

Pharmacy (LOCAL) Name: _____
City: _____ Phone Number: _____
Pharmacy (MAIL ORDER) Name: _____
Phone Number: _____

Current Psychiatric Medications: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful,

				5=Very Helpful

Past Psychiatric Medications: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful, 5=Very Helpful

Current NON-PSYCHIATRIC Medications / Vitamins / Supplements: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful, 5=Very Helpful

SOCIAL/LEISURE ACTIVITIES/HOBBIES (please list below):

_____ ____ _____

_____ ____ _____

_____ ____ _____

ROCHESTER CENTER
FOR BEHAVIORAL MEDICINE

Controlled Substance Contract

Controlled substance medications (stimulants, benzodiazepines and tranquilizers) can be effective in the treatment of certain mental health disorders. As controlled substances are highly regulated, the Rochester Center for Behavioral Medicine follows a stringent protocol when prescribing these medications.

Please review the following "patient responsibilities" and sign at the bottom to indicate your understanding of these policies.

Because my clinician is prescribing controlled substance medications as part of my treatment plan, I agree to the following conditions:

- I will attend appointments at the Rochester Center for Behavioral Medicine at the frequency deemed appropriate by my clinical team
- I give permission to the Rochester Center for Behavioral Medicine to access and review my prescription history at random intervals
- I will fully disclose to my treatment team all current medications, short-term and long-term and will notify my prescriber of changes to my medication regimen
- I am responsible for the medications prescribed to me. If my prescription is lost, stolen or misplaced or if I take more than what is prescribed to me, my prescription will not be replaced
- I give permission for my clinician to discuss my diagnosis and treatment with other clinicians providing my medical care.
- I will use only one pharmacy for all of my prescriptions. I will register the name and phone number of the pharmacy with my clinician and, should a change of pharmacy be necessary, I will let the office know.
- Refill requests from pharmacies will not be accepted
- I agree to undergo random urine drug testing per the protocol of the Rochester Center for Behavioral Medicine. The presence of illicit drugs or the absence of my prescribed medications will be considered a breach of contract and may be grounds for dismissal from the practice. Failure to comply with the screening will be considered grounds for dismissal as well.
- I will not request or accept controlled substance medications from any other clinician or individual while am receiving such medications from the Rochester Center for Behavioral Medicine
- I will not give, share or sell my medications to any other person

Name of Patient or Guardian: _____

_____ _____

Signature Date Signed

2/7/2018