Chicago Psychiatry Associates

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www.chicagopsychiatryassociates.org | contact@chicagopsychiatryassociates.org

Dear _____ Date: _____

This letter acknowledges your upcoming appointment on _____ We look forward to meeting with you then. In preparation for this initial appointment, we want to inform you of several aspects of our practice to make sure that you are both aware of, and comfortable with these features. Below is a summary of these points; more detailed description and explanation is on the following page.

First, we have a fee-for-service practice and do not participate with any insurance companies or accept insurance reimbursement. Each of us have our own fee structure which we provide when setting up our initial appointment. **We accept payment by cash, check or credit card (MasterCard or Visa).**

Second, we do not participate in Medicare or Medicaid.

Third, we have a cancellation policy requiring **two full business days** of advanced notice to cancel a session, **including your initial session**, in order to avoid a cancellation charge.

Please read carefully through all of the attached forms. **In order to confirm your appointment, you must complete, sign and return pages 3, 4, 5, and 12 of the attached forms.** These can be emailed, faxed or mailed back to us.

There is more explanation of these points and other information about our practice on the next page. Please read this. We want you to know how we work and what to expect.

Thank you and we look forward to meeting with you soon.

Sincerely,

John F. Gottlieb, M.D. | Susan Stern, M.D. | Kurt Kastenholz, M.D. | Megan Pirigyi, M.D.
Mark Chapman, M.D. | Indrany Datta-Barua, M.D.

Practice Information for Chicago Psychiatry Associates

Fee For Service. We do not participate in or accept reimbursement from any insurance companies. Our patients pay us directly and in full for their initial sessions at the time of service. We accept payment by check, cash or credit cards (MC or VISA). Many people that we see do, however, submit our bills for reimbursement from their insurance company. Here is the process: We will provide you with an itemized receipt for your appointments, which you would then submit to your insurance company. They will then reimburse you directly for whatever portion of the treatment they cover. If this is a concern for you, we strongly encourage you to clarify this before you begin.

We do not participate in Medicare or Medicaid. We ask all our patients to read, sign, and complete the attached Medicare Opt-Out Form indicating that you are aware of our non-participating status and that you agree not to submit any claims to Medicare.

Our ***cancellation policy*** requires that you give us two, full business days of advance notice to cancel a session without charge. Provided that you are not ill, we charge for all missed sessions, in full, without this advance notice of two, full business days. In addition, unless you have become suddenly ill or are incapacitated, we ask that you provide us with as much notice as possible if you are unable to keep an appointment, to avoid incurring a cancellation charge.

Charges for our time or services outside of your regularly scheduled appointments. During the course of your treatment, you may request that we complete forms for your insurance, review medical records, obtain authorization for prescriptions, talk with you by phone, or ask that we discuss your care with family members or other clinicians. If the time involved exceeds 5 to 10 minutes, you may be charged for these services.

Communicating with us. In keeping with the private nature of our practice, we each do our own billing and scheduling; we do not use administrative staff for this purpose. Hence, if you have a question or concern, please contact us directly. We use email for administrative and scheduling purposes only. We do not use it for clinical treatment or decision-making. If there is a problem, we prefer to discuss this directly, either by phone or in person.

Use of our office suite and waiting room. We do not use a receptionist in our practice. When you first arrive, you will enter our waiting room. There you will find a row of switches next to the inside door. Please lift the switch next to your Doctor's name to let them know that you've arrived. Have a seat and we'll be out at our scheduled appointment time. We request that you honor the privacy and confidentiality of our other patients by refraining from conversation or cell phone usage in our waiting room and the internal corridor of our office. Related, we have a separate exit in our suite and request that you use that (and not leave
through the waiting room door) when leaving our offices after your appointment.

Additional information about our practice, the initial consultation process, and pragmatic details about parking and public transportation is available on our website at:
www.chicagopsychiatryassociates.org Please let us know if you have any questions or concerns. If not, please sign, date, and return the following attached forms as soon as possible:

1. Practice Agreement Form. (Page 3)
2. Credit Card Payment Authorization Form. (Page 4)
3. Notice of Medicare Opt-Out Status. (Page 5)
4. Acknowledgement of Receipt of Privacy Notice. (Page 12)

You can scan and e-mail, fax, or mail these forms back to us. If you are uncomfortable providing your credit card information through these means, please call us and we can take the information over the phone.

Chicago Psychiatry Associates

Practice Agreement

☐ I have read, understand, and agree to the billing, cancellation and medical communication Policies of Chicago Psychiatry Associates.

☐ By checking this box, I acknowledge that I have read, understand, and agree to the information contained on the Practice Information form.

_____ _____

Signature Date

Name (Print): _____

Address: _____

City, State, Zip: _____

Telephone: cell: _____

work: _____

home: _____

Email: _____

Social Security: _____

Date of birth: _____

Chicago Psychiatry Associates

Credit Card Payment Authorization Form

You authorize charges to your Visa or MasterCard for any missed appointment fees or outstanding balances. Missed appointment charges will be made at the time of your scheduled session. A receipt will be mailed to you and the charge will appear on your credit card statement. You understand and agree that no prior-notification will be provided before these charges are made. Your credit card information will be stored in a secure, locked site in our office; no other staff or clinicians will have access to this. On termination of your treatment, this information will be destroyed.

Please complete the information below:

I,_____(print your full name) authorize Chicago Psychiatry Associates to bill my credit card for any and all missed appointment charges or outstanding balances for professional services rendered. These charges will be made when missed appointments occur or when balances are not paid for more than 30 days. I understand that I will not receive advance notice of these charges.

Account Type: ☐ Visa ☐ MasterCard

Cardholder Name: _____

Billing Address: _____

City, State, Zip: _____

Account Number: _____

Expiration Date: _____

CVV (3 last digits on back of card) _____

By completing this box, I acknowledge that I have read, understand, and agree to the information contained on this form.

SIGNATURE:_____DATE:_____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the scheduled payments with my credit card company provided the transactions correspond to the terms indicated in this authorization form.

Chicago Psychiatry Associates

Notice of Medicare Opt-Out Status

☐ I, (print your name), hereby attest to the following: I understand that (circle your physician) John F. Gottlieb, M.D., Susan Stern, M.D., Kurt Kastenholz, M.D., Megan Pirigyi, M.D., Mark Chapman, M.D., Indrany Datta-Barua, M.D. has opted out of Medicare under the Social Security Act.

☐ I accept full responsibility for payment of the physician's or practitioner's charge for all services furnished by the physician/practitioner.

☐ I understand that Medicare limits do not apply to what the physician/practitioner may charge.

☐ I agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare.

☐ I understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

☐ I enter into the contract with the knowledge of the right to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts with other physicians or practitioners who have not opted out.

☐ I understand that the effective date of the opt-out period is January 1, 2015.

☐ I understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

☐ I do not currently require emergency care services or urgent care services.

☐ Dr. Gottlieb, Stern, Pirigyi, Kastenholz, Chapman, or Datta-Barua has provided me with a copy of this contract.

☐ By checking this box, I acknowledge that I have read, understand, and agree to the information contained on this form.

_____ _____

Patient Date

_____ _____

Physician Date

Chicago Psychiatry Associates

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

You have the right to:

- Get a copy of your health and claims records
- Correct your health and claims records
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Answer coverage questions from your family and friends
- Provide disaster relief
- Market our services and sell your information

Our Uses and Disclosures

We may use and share your information as we:

- Help manage the health care treatment you receive
- Run our organization
- Pay for your health services
- Administer your health plan
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests and work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get a copy of health and claims records

- You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct health and claims records

- You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will consider all reasonable requests, and must say “yes” if you tell us you would be in danger if we do not.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say “no” if it would affect your care.

Get a list of those with whom we’ve shared information

- You can ask for a list (accounting) of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We’ll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for your care
- Share information in a disaster relief situation

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Help manage the health care treatment you receive

We can use your health information and share it with professionals who are treating you.

Example: A doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.

Run our organization

- We can use and disclose your information to run our organization and contact you when necessary.
- We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long term care plans.

Example: We use health information about you to develop better services for you.

Pay for your health services

We can use and disclose your health information as we pay for your health services.

Example: We share information about you with your dental plan to coordinate payment for your dental work.

Administer your plan

We may disclose your health information to your health plan sponsor for plan administration.

Example: Your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

How else can we use or share your health information?
We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls

- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests and work with a medical examiner or funeral director

- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you.

Other Instructions for Notice

- Effective November 1, 2013
- Privacy Official: Dr. John Gottlieb: (312) 782-5959; contact@chicagopsychiatryassociates.org

Chicago Psychiatry Associates

Acknowledgement of Receipt of Privacy Notice

I,_____(print your name) acknowledge that I have received a copy of the Privacy Notice.

_____ _____

Patient Signature Date