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**HMPS-Patient Services Agreement/Consent Form**

Welcome to Healthy Minds Psychiatry Services (HMPS) where we strive for excellence in providing the highest quality of psychiatric care to our late adolescent to adult and geriatric patients. To achieve this goal, we must have a mutual understanding regarding our professional services and your participation in your own treatment. This document contains important information about our services and business policies. **Please read them carefully.**

**HIPAA:** The Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. You may revoke this agreement in writing at any time. Please feel free to ask any questions regarding this matter at your first appointment. For more information **please visit** [www.hhs.gov](http://www.hhs.gov)

**Confidentiality:** Your privacy is important to us. All protected health information (PHI) will be kept confidential. In most cases we will obtain your consent prior to releasing any PHI; however, records and/or PHI may be released regardless of consent in the following circumstances:

- According to state and local laws, we must report to the appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled, and the elderly.
- According to state and local laws, we must report to the appropriate agencies all cases in which there exists a danger to self and/or others.
- When authorized by the recipient of services, to process medical insurance claims and authorized payment of benefits.
- If a patient needs emergency services and other medical personnel need to be contacted.
- If you become involved in specific kinds of legal proceedings, the courts may

subpoena information concerning your treatment.

**Office Hours:** The office is usually open Monday-Fridays, 9 AM to 6 PM and Saturdays from 9 AM to 1 PM by appointment. Information regarding holidays or vacations would be communicated in advance via telephone voicemail and website

**Psychiatric Services:**

We offer the following psychiatric services:

- Initial diagnostic interview.
- Follow up with medication evaluation, management, and therapy.
- Individual psychotherapy.

**Payment and Billing Policy:** Payment (i.e. cash pay, copays, payment towards deductible) **is due prior to your appointment on the day services are rendered.** If we are an in-network provider for your insurance, we will collect the portion of the fee that the insurance does not cover. Unless proof from the insurance company is provided at the time of the appointment stating that your deductible has been met, all deductibles will be due at the time of the appointment. If your account is not paid in a timely manner and arrangements for payment have not been agreed upon, we have the option of using legal means to secure the payment. This may involve hiring a collection agency, hiring an attorney, or utilizing other options, which will require me to disclose otherwise confidential information. In most collection situations, the information released includes the patient's name, contact information, the nature of services provided and the amount due. If such legal action is necessary, these costs will be included in the claim.

**We do not accept checks but do accept cash (exact amount) and credit card payments (Visa, Mastercard, American Exp, and Discover).**

\*If there is a change in your insurance coverage, your address, or other important demographic information between appointments, please let us know when you check in.

**Cancellation Policy:** Once an appointment is scheduled, you will be expected to arrive on time and pay for the visit, unless you provide at least one business day's advance notice of cancellation. For example, an appointment for Monday needs to be cancelled before close of business on the Friday before, to avoid a missed appointment charge. Please know that insurance companies do not provide reimbursement for no-show appointments and/or appointments that you do not cancel with sufficient notice. A missed appointment fee will be charged for an appointment not cancelled with sufficient notice or for a no-show appointment. For example, if a 30-minute appointment is missed, you will be charged my fee for that type of appointment. As a courtesy, we try and confirm upcoming appointments by phone. Please realize that you are responsible for appointments that you schedule.

**Late Policy:** Please arrive on time for your appointment. Patients arriving more than 10 minutes late may be asked to reschedule.

**Professional Records:** We keep protected health information (PHI) about you in medical record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be confusing if read without the guidance of a mental health professional. For this reason, we recommend that you initially review them with me, or have them forwarded to another mental health professional so you can discuss the contents. In most circumstances, a copying fee of \$25.00 or more will be charged. If we refuse your request for access to your records, you have a right of review, which we will discuss with you upon your request. Insurance companies can request and receive a copy of your clinical record.

**Emergency/Afterhours Service:** If you need emergency services, call 911 or proceed to the nearest hospital emergency room. If you have an urgent after-hours issue which cannot wait until the next business day, you may call the office number 571-559-2100 and follow the recorded message instructions for how to contact the on-call physician. This option is reserved for urgent issues ONLY and does not apply to refill requests or scheduling issues.

**Telephone contact fees:** We may charge you a fee for telephone calls relating to your care, with charges based on the amount of time spent. We charge a minimum of \$25 for non-urgent after-hours telephone calls, with charges based on the amount of time spent.

**Psychotropic Medications Policy:** I hereby consent to receive psychotropic medications as prescribed by Dr. Bahl. I have been informed of all the side effects and adverse reactions to the medications. I understand that I may experience withdrawal symptoms if I abruptly stop taking my medications. I understand that, on occasion, some psychotropic medication may be used for psychiatric conditions and symptoms, despite a lack of FDA approval for these uses. I had the opportunity to discuss my concerns and the possible risks, benefits, precautions, and side effects associated with the medication(s).

**Medication Refill Policy:** Refill requests need to be called in to the office *at least 3 to 5 business days* in advance of the date they are needed. It is your responsibility to contact the office before you run out of medications. If your prescription expires before you take it to the pharmacy, you will need to contact the office to request a new prescription. There is a \$10.00 fee to rewrite any expired prescriptions. All medications, Except Controlled Substances your pharmacy can FAX a refill request to the office. Refills will only be written or faxed Monday through Friday. Refills will not be addressed after hours or by the on-call physician. If you supply our office with a self-addressed stamped envelope, we can gladly mail your prescription directly to

you. Otherwise, prescriptions need to be picked up from our office during normal business hours  
**Follow up visits:** We require that patients on psychiatric medication be seen at least once every 90 days. If a patient has not been seen in the office in the last 90 days, we will not issue a refill without a scheduled follow-up appointment.

**Forms and Letter:** Any additional paperwork, letters, or forms not specifically related to intra-office care, will be subject to a fee based on the time it takes to complete the documentation (\$15 for up to 10 mins, \$25 for 11-30 min, \$50 for 31-60 min, etc.) which will need to be paid prior to release of the paperwork.

**Consent to Disclose:** List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from Healthy Minds Psychiatry Services.

**Name and Relations Allowed**

Spouse: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Consent for Treatment:** I have read the entire agreement and I fully agree with its contents. I voluntarily give my permission to the healthcare providers of Healthy Minds Psychiatry Services as they may deem necessary to provide mental health services to me.

I understand by signing this form, I am authorizing the clinicians of Healthy Minds Psychiatry Services to treat me for as long as I seek care from them until I withdraw my consent in writing.

Signature: \_\_\_\_\_ Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Legal guardian name (if applicable): \_\_\_\_\_

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