Dr. Michael P. Twist – Psychiatry, LLC

Adult, Adolescent, and Geriatric Psychiatry

Authorization to Use and Obtain and/or Disclose Health Information

Patient Name: _____ Date of Birth: _____

I authorize Dr. Michael P. Twist, DO to [ ] use or [ ] disclose and/or [ ] obtain the above named individuals health information as described, concerning the period from _____

This information may be used by Dr. Michael P. Twist, DO and obtained from and/or disclosed to and used by the following individual/organization:

Name: _____ Phone: _____ Fax: _____

Address: _____

Purpose: [ ] assessment / [ ] treatment / other [ ]: _____

Special Instructions / limitations: _____

Release and/or obtain:

[ ] Intake / Psychiatric Assessment [ ] Labs/ EKG / Imaging [ ] Progress Notes

[ ] History and Physical [ ] Other: _____

I understand that this information is psychiatric in nature and may include results of evaluation and clinical assessment, psychiatric data, as well as business transactions including accounts, billing, and insurance. I understand I can specifically limit the information provided and these limitations can be listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Michael P. Twist, DO. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. This authorization will expire in 1 year.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Dr. Michael P. Twist, DO at 860-967-0405.

I understand that I am giving permission for Michael Twist, DO to provide information that would otherwise be confidential and privileged under Connecticut Law. I voluntarily give this permission.

_____ _____

Signature of Patient Signature of Witness

_____ _____

Signature of Patient's Legal Guardian/Parent (if patient is under 18 years of age) Date Signed

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HIPAA Summary

The following is a required "notice of privacy practices" (NPP) in keeping with Federal HIPAA (Health Insurance Portability and Accountability Act, 1996) requirements.

Overview of Privacy Issues:

The laws regarding privacy of personal health information are complicated. The information in your records is known as Protected Health Information, or PHI. I will not use or disclose your PHI without your authorization, except as described in this notice. I am not permitted to provide treatment without an executed consent form. You also may have additional questions or concerns, including about situations not covered by this information, and you are encouraged to voice these.

The health information in your records will be mainly used to provide treatment, to arrange payment for services, and for some other business activities that are called, by the law, "health care operations". Before private information can be disclosed (sent, shared, or released) for any additional purposes, a separate authorization form is required to allow it.

Your health information is private and will be kept that way, but there are some times when the law requires disclosure. For example:

1. When there is a serious threat to your health or safety or the health or safety of another individual or the public. Information would then be shared with a person or organization that is able to help prevent or reduce the threat.
2. Some lawsuits and legal or court proceedings.
3. Abuse or Neglect and associated judicial proceedings.
4. Adjudicated Youth
5. If a law enforcement official requires that I do so.
6. For Workers Compensation or similar benefit programs.
7. There are some other situations like these but which happen very rarely.

Your Rights Regarding Your Health Information:

You can ask me to communicate with you about your health and related issues in a particular way or at a certain place for more privacy

You can request that I limit what I disclose to any people who are involved in your treatment or the payment for treatment, such as family members or friends. If I agree to the request, I would attempt to keep that agreement except if it is

against the law, or in an emergency, or when the information is necessary to treat you.

You have the right to look at your health information, such as billing records or health records, such as psychotherapy notes. You can even get a copy of these, provided you reimburse for time and copy expenses involved.

If you believe that any information in your records is incorrect or missing important information, you can ask to make some kinds of changes (termed "amending") to your health information. You would have to make such a request in writing and send it to my office, and you would also need to write the reasons that you want to make the changes.

You have the right to a copy of this notice and to the longer NPP. If I make any changes to either form, I will make sure that they are readily available to you.

You have the right to file a complaint if you believe that your privacy rights have been violated. You can file such a complaint with me personally and with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Filing a complaint regarding privacy will not in itself change the health care that you receive at this office.

If you have any questions regarding this notice or the health information privacy policies at this office, please contact Michael Twist, DO, for the purposes of the above issues.

The effective date of this notice is November 1, 2016.

I understand that my records are protected under the federal regulations contained in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191.

I also understand that I may restrict or prohibit certain uses and disclosures at any time, except to the extent that action has been taken in reliance on previously released information.

_____

Signature of Patient **Date**
(or authorized representative when required)

_____

Michael P. Twist, DO **Date**
(confirmation that patient received copy of notice)

Dr. Michael P. Twist – Psychiatry, LLC

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Consent for Treatment – Outpatient Services Contract – Patient Information

Welcome to my practice. This document contains important information about my professional services and business policies. Please read it carefully and feel free to ask any questions that you might have. When you sign this document, it will represent an agreement between us. If you request it, you will be provided with a copy of this form after you have signed it.

Professional Services

As a Medical Doctor and Board Certified Adult, Adolescent, and Geriatric Psychiatrist, I am trained to see patients across the age spectrum. Services include assessments, diagnosis, on-going medication treatment if warranted, brief supportive and behavioral therapy as part of medication follow-up and individual therapy on a case by case basis.

I also realize that children cannot not be seen without proper consultation with all providers involved, therefore, with your consent, I will be in contact with the child's therapist, pediatrician, school, or other providers as treatment necessitates. The success, length, and course of treatment are affected by many things, including the severity of the problem and the motivation of the patient, among other factors. The best outcome is achieved through collaboration between the patient and provider.

I do not provide forensic services such as custody evaluations, ability to stand trial, etc. If you are in the process of a divorce or custody dispute, it must be disclosed immediately.

Confidentiality

Communication between a patient and his/her mental health provider is held in confidence and will not be revealed to an outside agency without written consent unless specifically required by law (for example: child abuse, imminent threat of danger to yourself or others, court order, etc). Information released to insurance companies for reimbursement for services is released only on authorization from you.

If the patient is under 18 years of age, the law may give parents/legal guardians the right to access your records. It is my policy to request an agreement from parents that they will relinquish this right so that patients under 18 (especially teenagers) may have privacy in their sessions. An exception to this would be if I believe that here is a risk of imminent danger to oneself or others.

Psychiatrists often find it helpful to consult about a case with other professionals. In these cases, details that would reveal the identity of my patient are avoided. The consultant is, of course, also ethically bound to keep the information confidential.

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Appointments, Cancellations, and No Show Policy
Please remember that your appointment time is reserved for you. Appointments cancelled less than 24 hours in advance or if the appointment is not kept, will be charged the full appointment fee. Please note that these charges are not reimbursable by insurance companies. Exceptions can be discussed.

This office does not call to remind you of your appointment, so please keep track of your appointment card. If you are unable to cancel a routine, non-urgent follow-up session in time, phone appointments are possible at the standard appointment rate.

If multiple appointments are missed without notice, I reserve the right to terminate treatment and refer you elsewhere.

Telephone Calls, Communication, and Letters
I do try to check my messages throughout the workday. Brief phone calls are not charged. Longer, more involved calls are charged as outlined in Professional Fees. The best way of reaching me is by calling 860-967-0405 and leaving me a message. I try to return urgent calls as soon as possible and routine calls are usually returned within 24- 48 hours during the work week.

For true medical emergencies please call 911 or go to your closest emergency room.

On a few occasions when I am out of town, I may have another clinician or physician available for urgent calls.

Forms may need to be filled out for schools and camps, etc. Routine, brief forms are filled out at no charge. Extended or complex forms or letters and full psychiatric reports will be charged as outlined in the Professional Fees.

Prescription Refills
Prescription refills can be called into my voicemail. Please allow 5 full business days for receipt of a mailed prescription and 2 full business days for ones that can be called in to a pharmacy.

If a medication has been prescribed, I urge you not to modify it without contacting me first. Abrupt termination of some medications prescribed may have serious adverse effects. Please discuss any medication changes with me, including medications added or changed by you or other medical providers.

I will also be in constant contact (with your consent) with your primary care physician or your child's pediatrician to keep them updated as to any medications I may prescribe for you or your child.

Payments and Insurance
Payments are expected at the time of service regardless of your insurance coverage. I do not file insurance claims nor do I accept any insurance plans or payments. Please verify your out-of-network benefits as most insurance companies do provide some coverage for mental health treatment. Since coverage varies widely from policy to policy, I cannot guarantee that these services will be reimbursed by your insurance carrier.

If you wish, you may file for reimbursement directly with your insurance carrier. At the time of payment, you will be provided a super-bill. This will include the diagnosis code and billing code for the appointment. Some insurance companies may require documentation of the diagnosis and a treatment plan or summary.

You are responsible for all fees.

Returned checks will be assessed a $25 office administrative fee as well as any bank charges. All accounts become overdue after 30 days if no payment arrangement has been made. I will make every effort to cooperate with any individual who has special financial concerns. Severely past due accounts may be sent to a collection agency and any collection costs will be added.

Discontinuation of Treatment, No Contact Policy
Typically, the decision to terminate treatment is made through a mutual and thoughtful discussion involving the physician and patient (and parents). In the event that you discontinue treatment without notifying my office, I will assume that your therapeutic relationship with me terminated 90 days after your last visit (unless you have an appointment scheduled for a future date) beyond which I carry no further responsibility for your care.

This is a great deal of information to review, so please feel free to contact me with any questions and I look forward to working with you and your family.

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I acknowledge that I have read, understand, and accept this policy and consent for treatment of myself or my minor child listed herein and accept responsibility for all fees incurred. If the patient is a minor child, I acknowledge that I have the legal authority to consent for treatment of this child. I understand that I have the right to withdraw consent at any time.

Patient's Name: _____ **Date of Birth:** _____

Responsible Party Name: _____

Relationship (If Not Patient): _____

Address: _____

Phones (Home, Work, Cell): _____

_____

Signature (Responsible Party) **Date**

_____

Michael P. Twist, DO **Date**

Credit Card Type: _____

Credit Card #: _____

Expiration Date: _____ **Security Code:** _____

ZIP code associated with Credit Card: _____

Name as it appears on Credit Card: _____