

**Guiding Balance**  
122 West Roe Blvd.  
Patchogue, NY 11772  
(O) 631-260-1314 (F) 631-532-1981

**Terms and conditions of treatment**

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Responsible Party:** \_\_\_\_\_

**Emergency Contact:** \_\_\_\_\_

**Credit Card Information:**

**Name:** \_\_\_\_\_

**Number:** \_\_\_\_\_

**Expiration:** \_\_\_\_\_

**CVC:** \_\_\_\_\_

**Consent Of Treatment**

- The patient certifies that he or she has at least 18 years of age and consents to the rendering of such evaluation and treatment by a healthcare provider practicing at the aforementioned practice. Should the patient not be 18 years OR older, aforementioned responsible party consents to the rendering of such evaluation and treatment by the practitioner for the patient. The patient and/or responsible party shall be aware that clinical practice is not an exact science and shall acknowledge that no representations, guarantees, or warranties have been made to the patient as to the result of any evaluation or treatment procedure that the patient may receive.
- Should a responsible party be indicated, he or she shall accept the remaining terms in this agreement on behalf of the patient.

**Medication guidelines**

- All medications shall be taken at the dose and frequency prescribed. No other psychotropic or narcotic medications are to be taken unless discussed first with this practitioner.
- All patients shall comply with scheduled appointments. If the patient cancels an appointment it is the patient's responsibility to ensure he or she has enough medication until the next visit.
- Medications will not be refilled without the appropriate medication management office visit. This is to ensure that the medications are beneficial to the patient. If you require refills on prescriptions please discuss at the start of your visit.
- If you are prescribed a controlled substance you must be seen monthly this is a New York State mandate.
- If you are not prescribed a controlled substance you must be seen at the very least every three months, no exceptions.

- The Patients shall not request other psychotropic medications from other providers while in treatment in this practice.
- All patients will consent to random drug testing. This is a New York State mandate.
- All patients are responsible for protecting their own prescriptions. Lost or stolen medications will not be replaced. this is a New York State mandate.
- All patients/guardians will keep medication locked away from others.
- All patients shall inform other healthcare providers of treatment being administered by this practice.
- All patients shall agree to participate in psychiatric, neuropsychological, and substance-abuse assessments if indicated.

### **Appointment guidelines**

- All appointments must be made in a minimum of 14 days in advance of running out of prescriptions. Please plan ahead.
- Cancellations made within 24 hours of appointment will have a \$75 late cancellation fee.
- No-shows will have a \$75 cancellation fee.
- Active credit card information will be obtained and kept on file to be charged for late cancellations, No-Shows, and unpaid balances.
- In the event of inclement weather, the office may be closed and these fees will be waived. Telepsychiatry sessions may be offered at the discretion of the practitioner.
- Patients may be discharged for missing three appointments in a one-year period.
- Emails, text, and voicemails will not be answered after 6:00 PM on weekdays and never on the weekends. Responses will be made within 24 hours. In case of an emergency call 911.

### **Health insurance portability and accountability act of 1996 (HIPAA)**

The patient understands that under the HIPAA guidelines all patients have a certain right to privacy regarding the patient's protected health information. The patient understands that his information may and will be used to do the following:

- Conduct, plan, and direct the patient's treatment along with following up with the multiple healthcare providers who may be involved in the treatment; both directly or indirectly.
- Obtain payment from third-party payers.
- Conducted normal healthcare operations such as assessments and physical certifications.

The patient may request in writing that he or she may restrict how his or her private information is used or disclosed to carry out the patient's treatment, payment, or health care operations. The practitioner is not required to agree to the patient's requested restrictions but if the patient agrees that he or she is bound to abide by such restrictions.

### **Paperwork**

If paperwork is required to be completed by the practitioner outside of his or her appointment there will be a \$7.50 per page fee.

### **Agreement**

The patient and/or responsible party hereby acknowledge and agrees to all the terms, conditions, and information above.

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Patient/ Responsible Party      Date

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Review by: Amanda Weston PMHNP-BC