Notice of Psychiatrists' Policies and Practices
to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW MENTAL HEALTH AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. This information is required under the Health Insurance Portability and Accountability act (HIPAA) passed by congress in 1996.

I. Uses and Disclosure for Treatment, payment, and Health Care Operations

I may *use* or *disclose* your *protected health information (PHI)*, for *treatment, payment, and health care operations* purposes with your *consent.* To help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*

  - *Treatment* is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as you family physician or another psychiatrist.

  - *Payment* is when I obtain reimbursement for your health care. Example of payment is when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of [office, clinic, practice group, etc.] Such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosure Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment and health care operations when your appropriate authorization is obtained. An *"authorization"* is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment and health care operations, I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your psychotherapy notes. *"Psychotherapy notes"* are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of you medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or psychotherapy notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provided the insurer the right to contest the claim under the policy.

III. Uses and Disclosure with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If I have cause to believe that a child has been, or may be, abused, neglected, or sexually abused, I must take a report of such within 48 hours to the Texas Department of Protective and Regulatory Services, The Texas Youth commission, or to any local or state law enforcement agency.
- **Adult and Domestic Abuse:** If I have cause to believe that an elderly or disabled person is in a state of abuse, neglect, or exploitation, I must immediately report such to the Department of Protective and Regulatory Services.
- **Health Oversight:** If a complaint is filed against me with the Texas State Board of Social Worker Examiners, they have the authority to subpoena confidential mental health information from me relevant to that complaint.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information, without written authorization from you or your personal or legally appointed representative, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- **Serious Threat to Health or Safety:** If I determine that there is a probability of imminent physical injury by you to yourself or others, or there is a probability of immediate mental or emotional injury to you, I may disclose relevant confidential mental health information to medical or law enforcement personnel.
- **Worker's Compensation:** If you file a worker's compensation claim, I may disclose records relating to your diagnosis and treatment to your employer's insurance carrier.

IV. Patient's Rights and Psychiatrists' Duties

- **Patient's Rights:**
- *Right to Request Restrictions* - You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, I am not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, I will send your bills to another address.)
- *Right to Inspect and Copy* - You have the right to inspect or obtain a copy (or both) of PHI and psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- *Right to Amend* - You have the right to request an amendment of PHI for as long as the PHI is maintained in the record, I may deny your request. On your request, I will discuss with you the details of the amendment process.
- *Right to an Accounting* - You generally have the right o receive an accounting of disclosures of PHI for which you have neither provided consent or authorization (as described in section III of this Notice). On your request, I will discuss with you the details of the accounting process.
- *Right to a Paper Copy* - You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Psychiatrists' Duties

- I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.
- If I revise my policies and procedures, I will provide you with a written copy by mail.

V. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy right, you may contact me at 346-2332.

If you believe that your privacy rights have been violated and wish to file a complaint with *me/my* office, you may send your written complaint to me at 8140 North Mopac, 2-200, Austin, TX 78759.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. The person listed above can provide you with the appropriate address upon request.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VI. Effective Date of Privacy Policy

Effective on April 14, 2003.

I have received a copy of this document.

_____ _____

Client Signature Date

Consent to Treatment with Psychoactive Medication
Information Sheet

Consumer's Rights Under the Consent to Treatment with Psychoactive Medication Rule

General Information Regarding Rights and Consent

You have the right to decide whether to take this medicine as recommended by your doctor. You can agree to take the medicine; this agreement is called "consent." You have the right not to agree to take this medicine. If you do not agree to take or if you object to taking the medicine, your objection will be recorded in your medical file. You have the right to withdraw your consent to treatment with psychoactive medications at any time.

There may be a person who is authorized to agree or object for you. That person is called your "legally authorized representative." Your "legally authorized representative" can be one of your parents if you are a minor and did not admit yourself or a person appointed by a court to look after your well-being, usually called a guardian. No other person can consent or object for you.

You have the right to know what may happen if you do not choose to take the medicine. If you are under a court ordered temporary or extended commitment, your doctor may petition the court for approval to prescribe and administer psychoactive medication(s) despite your objections. You have the right to be represented by an attorney and to appeal the judge's decision. You should be told whether not taking the medicine might cause the occurrence, increase or reoccurrence of mental illness.

You have the right to be informed about and to discuss with your doctor and other types of treatment your doctor thinks can reduce or control your symptoms and help you feel better. You are entitled to know this before you give your consent or before you make an objection to taking the medicine. You have the right to know how the medicine will be given to you, how frequently and for how long it will be given to you.

You have the right to know that all medicines have side effects; some are mild and some severe. Some side effects may be permanent. You have the right to know this before giving your consent or making your objection to taking the medicine.

You have the right to know what side effects might occur if you take the medicine. You have the right to know which side effects you, as an individual, may likely experience. You have the right to know what kind of permanent problems may occur because of taking this medicine for a long time or in a large amount. Written material which describes the risks and benefits of the medicine will be given to you, and read if necessary, to you or your legally authorized representative before medication is administered to you.

You need to immediately tell your doctor or the staff if you have any problems while taking the medicine. You should always tell your doctor or the staff about any other medicines you are taking or are allergic to.

After these things have been explained to you, you still have the right to object to the medication. However, you may be given appropriate medication without your consent if there is a situation in which it is immediately necessary to give mediation to you to prevent:

1. imminent or probable death or substantial bodily harm to yourself if you:
    a. openly or continually threaten or attempt to commit suicide or serious bodily harm,

or

    b. are behaving in a manner that indicates that your are unable to satisfy your need for nourishment, or essential medical care, or self protection, or there is

2. imminent physical or emotional harm to others because of your threats, attempts, or other acts which are openly or continually made or done.

If your medication and/or group(s) of medicine is to be changed or the way of taking the medicine is to be changed, you again, have the right to be informed of the change. Information should be given to you about any new medicine or any changed in your medication including how it will be give to you (pill, liquid, or injection), how much you will receive at one time, and when you will receive the medication.

Patient Signature Date

Legal Qualified Representative Relationship to Patient Date

Jane Kang M.D.
8140 North Mopac Expressway, Bldg.3, Suite 225
Austin, Texas 78759
Phone: 512-346-2332 Fax: 512-346-2284

Patient Services Contract

1. If you have an emergency, please call 911 or go to the nearest emergency room. If you have an urgent matter, please call (512) 346-2332 and leave me a voicemail. Dr. Kang will return your call the next business day. If it is a relatively simple matter, we can address over the phone. If it is more complicated, I will ask you to schedule a follow up appointment.

2. Dr. Kang currently takes Blue Cross/Blue Shield. If you are not on this plan, you will need to pay at time of service. We can provide a receipt of service to be filed for out-of-network reimbursement with your insurance company.

3. Current fee schedule (for self-pay patients)

Initial Evaluation	$350
50-60 minute follow up session	$205
20-30 minute follow up session	$130
Prescription prior-authorization	$40
Letters, forms (per page)	$20

4. Prescriptions: prescriptions should be filled during your appointment and you should have enough refills to get you through to your next scheduled office vist, Dr. Kang will have to see you at minimum every six (6) months to refill medications.

5. Dr. Kang does not do legal/forensics work, but if unavoidable legal issues do arise, Dr. Kang will charge $500 per hour for legal issues. Fee applies to: phone calls/discussions related to legal issues, legal consultation, expert testimony, documentation, and travel time. This fee must be paid in advance.

I have read and understand the above information and agree to these terms

Signature _____ Printed Name _____ Date _____

Jane Kang M.D.
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Financial Policy

INSURANCE

Knowing your insurance benefits is your responsibility. Prior to your first appointment, please make sure that you have mental health benefits, how many visits are covered, and that I am a provider on your plan. If I am not contracted with your health insurer, you are solely responsible to pay your bill in full according to my self pay fee rates.

If your insurance changes in any way, please notify us before your next visit so we can make the appropriate changes in our system or you will be billed for any uncovered services.

You may have a deductible under your insurance plan; this will be your personal financial responsibility.

CO-PAYMENTS

Co-pays must be paid at the Front Desk at the time you check in for your appointment. Please note that insurers require co-pays to be collected at the time of service.

DELINQUENT ACCOUNTS

If your account is over 30 days past due, you will receive a letter stating that you have 30 days to pay your account in full. I reserve the right to refuse further service to you until the past due balance has been paid.

If you are unable to pay the outstanding balance in full, please discuss with our Office Manager about a payment plan.

Please be aware that if a balance remains unpaid, we will refer your account to an outside collection agency and you may be discharged from the practice. If discharge occurs, you will be notified by regular and certified mail that you have 30 days in which to find alternative medical care. During that 30 day period, I will only be able to treat you on a strictly emergency basis.

RETURNED CHECKS:

A fee of $45, in addition to the face value of the check, is charged for all NSF (not sufficient funds) and ISF (insufficient funds) returned checks. All future payments must be made in cash or by credit card.

By signing below, I acknowledge that I have read, I fully understand, and I agree to the terms of this Financial Policy.

Signature	Printed Name	Date signed & acknowledged

Jane Kang M.D.
8140 North Mopac Expressway, Bldg.3, Suite 225
Austin, Texas 78759
Phone: 512-346-2332 Fax: 512-346-2284

Insurance Information

Insurance Company Name _____

Phone Number _____

Insurance ID# _____

Policy Holder Name _____

Date of Birth _____

Group Number# _____

Insurance Authorization # _____

Insurance Effective Date _____

Please contact your insurance company to verify your outpatient mental health benefits, co-pay amount, and obtain your insurance authorization/ request ID number, if applicable.

I called my insurance company to verify my outpatient benefits on (date): _____

My co-pay for each visit is: _____

My insurance company issued me the following authorization number: _____

This authorization is for _____ number of sessions

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Appointment Policy -- IMPORTANT

1. Please read thoroughly and print a copy for your records.

2. Your appointment is time set aside for you, which is why there is very little waiting for your appointment. I make it a priority to start your priority on time.

3. Because of this, it is important that you attend your appointments as scheduled and on time.

4. If you are 15 minutes late for a routine appointment or 20 minutes late for a long appointment, I will likely be unable to see you, as this will run into the next person's time. You wil have to reschedule.

5. If you are unable to make your appointment, I require that you cancel 24 hours in advance.

6. Missed appointments without 24 hour notification, or signficantly late arrivals, will be considered a "No Show Appointment."

7. You will be charged the full self-pay fee for a No Show Appointment. Please be aware that tyou will ahve to pay this yourself, as insurance will not pay for this.

8. Exceptions can be made for certain situations, but will only be considered on a case-by-case basis.

9. After three (3) No Show Appointments in a year, you will be dismissed from my clinic for not complying with your treatment.

It is your responsibility to keep track of your appointment dates and time. We do provide a reminder service via phone, email, or text message. The attached sheet gives instructions needed to receive these reminders. Select the best method for contacting you.

I have read and understand the above information and agree to these terms

Signature	Printed Name	Date

Appointment Reminder

You can receive an appointment reminder to your email address, your cell phone (via text message), or your home phone (via a computer generated voice message) the day before your scheduled appointment.

Your Name (please print): _____

Where would you like to receive appointment reminders? **Check ONLY one please.**

☐ Your home phone: _____
Via an automated telephone message to my home phone

☐ Your email address: _____
Via an emai message to the address listed above.

☑ Your cell phone number: _____
Via a text message on my cell phone (normal text message rates will apply).

This service is provided as a courtesy. A 3rd party is used to handle these reminders, and although the delivery rate is at 99%, there are circumstances where messages will not be successfully delivered (if users are on the phone, out of service, etc.). It is YOUR responsibility to record and keep any appointments that have been made, as we cannot guarantee you will successfully receive a reminder every time.

Appointment information is considered to be “Protected Health Information” under HIPPA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have instructed above.

Signature	Printed Name	Date

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Patient Information

Patient Contact

PATIENT NAME | MARITAL STATUS | DATE OF BIRTH

HOME ADDRESS | CITY | STATE | ZIP

HOME PHONE | CELL PHONE | WORK PHONE | WHAT IS THE BEST NUMBER TO USE?

PATIENT'S EMPLOYER | OCCUPATION

Emergency Contact

IN CASE OF EMERGENCY, CONTACT: | RELATIONSHIP | PHONE NUMBER

Preferred Pharmacy

NAME | ADDRESS | PHONE NUMBER

Medical Information and History

PLEASE LIST ALL ALLERGIES

MEDICAL CONDITIONS | TREATED BY

PREVIOUS SURGERIES

PREVIOUS PSYCHIATRIC HOSPITALIZATIONS AND DATES

WHAT PSYCHIATRIC MEDICATIONS HAVE YOU PREVIOUSLY TRIED?

FAMILY MEMBERS WITH PSYCHIATRIC DIAGNOSES

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Please list all of the medications you are taking now: prescribed, over the counter, herbal medications and vitamins.

Name of medication	Dose	When do you take it?	Who prescribes this?	Why do you take it?