



## Michelle Rickerby MD

Family Psychiatry Collaborative  
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## PSYCHIATRIST PATIENT SERVICES AGREEMENT

Welcome to my practice. This document (the Agreement) contains important information about my professional services and business policies. It also contains summary information about 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.

HIPPA requires that I provide you with a Notice of Privacy Practices (separate notice) for use and disclosure of PHI for treatment, payment, and health care operations. The Notice, which you have received along with this Agreement, explains HIPPA and its application to your personal health information in greater detail. The law requires that I obtain your signature acknowledging that I have provided you with this information. Although these documents are long and sometimes complex, it is very important you read them carefully. I can discuss any questions you have about the policies. When you sign this document, it will also represent and agreement between us. You may revoke this Agreement in writing at any time. That revocation will be binding on you and me unless either or both of us have taken an action in reliance on it.

### Billing and Payments

Payment is required at time of service. (See fee schedule.) You are financially responsible for all missed appointments. You must cancel your appointment with a minimum of 24 hours business day notice, otherwise you will be charged for the appointment.

- A \$25 fee will be assessed in the event of a returned check.
- Missed appointments: Calls must be made in no less than 24 hours (business day) of your appointment with the exception of illness. The first time there is a late cancellation or no show, the charge will be ½ (one half) of the regular charge for that appointment. For subsequent late cancellations and missed appointments, full fee will be charged for the office visit. Keeping a scheduled appointment is the patient's responsibility.
- If payments are not made for services I reserve the right to suspend treatment, with appropriate notice, and I will assist in making a referral elsewhere until payment is remitted. I will send copies of your record upon receipt of authorization.
- Payment is due at the time of service unless other financial arrangements have been made prior to treatment. A collection agency will be employed in the event payments become 60+ days overdue. The patient is to pay all attorney fees and collection costs in the event of default of charges.
- In event of inclement weather, it is the patient's responsibility to call and cancel the appointment if he/she does not feel safe traveling.



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If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon, I have the option of using legal means to secure the payment. This may involve hiring a collection agency or going through small claims court which will require me to disclose otherwise confidential information. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

### Limits on Confidentiality

The law protects the privacy of all communication between a patient and a psychiatrist. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA (The Health Insurance Portability and Accountability Act of 1996). There are other situations that require only that you provide written consent. Your signature on this Agreement provides consent for those activities as follows:

- 1 I may find it helpful to obtain collateral information from other health and mental health professionals and other sources (for example, teachers and/or school officials) about your case. I will provide a HIPAA compliant Release of Information form from the patient and/or the patient's guardian. I will note all obtained information in your Clinical Record.
- 2 I may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, I will make every effort to avoid revealing the identity of the patient. The other professionals are also legally bound to keep the information confidential. I will note all consultations in your Clinical Record.
- 3 If a patient threatens to harm himself/herself, I may be obligated to recommend hospitalization for that patient and/or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- 1 If you are involved in a court proceeding and a request is made for information concerning the professional services that I provide you, such information is protected by the psychiatrist-patient privilege law. I cannot provide any information without your written authorization or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.
- 2 If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- 3 If a patient files a complaint or lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.
- 4 If I am providing treatment for conditions directly related to a worker's compensation claim, I may have to



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submit such records, upon appropriate request, to Chairman of the Worker's Compensation Board on such forms and at such times as the chairman may require.

There are some situations in which I am legally obligated to take action in an attempt to protect others from harm. In these circumstances, I may have to reveal information about a patient's treatment. These situations are unusual in this practice.

1 If I receive information in a professional capacity from a child, parents, guardian, or other custodian that gives reasonable cause to suspect abuse or neglect of that child, the law requires me to make a report to The Child Protective Services. Once a report is filed, I may be required to provide additional information.

2 If a patient communicates an immediate threat of serious physical harm to an identifiable victim, I may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If such a situation arises, I will make every effort to discuss it fully with you before taking any action, and will limit disclosure to what is necessary.

While this written summary of exceptions to confidentiality should provide helpful information about potential problems, it is important that we discuss any questions or concerns that you may have. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

### Professional Records

The laws and standards of my profession require that I keep Protected Health Information about you in your Clinical Record. Except in unusual circumstances that involve danger to yourself and/or others or where information has been supplied to me confidentially by others, you may examine or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers and access may be denied. For this reason, if access is granted, I will review them with you in my presence. If I refuse access to your records, you have a right to a review, which I will discuss with you upon request.

### Patient Rights

HIPAA provides you with rights with regard to your Clinical Record and disclosures of protected health information. These rights include the following: requesting restrictions on what information from your Clinical Records is disclosed



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to others, requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized, determining the location to which protected information disclosures are sent, having any complaints you make about my policies and procedures recorded in your records, and the right to a paper copy of this Agreement and the attached Notice form. I am happy to discuss any of these rights with you.

**Minors and Parents**

Rhode Island law requires that both a minor and a parent are required to consent for mental health treatment.

**Insurance Information**

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis. Sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, I will make every effort to release only the minimum information about you that is necessary for the purpose required. This information will become part of the insurance company files and will probably be stored in a computer. Though all insurance companies claim to keep such information confidential, I have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national information data bank. I will provide you with a copy of any report I submit, if you request it. By signing this Agreement, you agree that I can provide requested information to your carrier.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPAA notice form described above.

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

Michelle Rickerby, MD: \_\_\_\_\_ Date: \_\_\_\_\_