NeuroScience & TMS
Treatment Centers

The NeuroScience & TMS Treatment Center is a full service clinic offering Psychiatric Consultation, Individual Evaluations, Follow up appointments, and treatment with medication, individual, couples, and family psychotherapy as well as specific Interventional Psychiatric treatments (TMS, Esketamine, and VNS) at many locations in Middle Tennessee. In addition, we have Comprehensive Team Evaluations with our therapy division called Nashville Center for Hope & Healing.

We work to help all patients get well. We want to be transparent about the policies so patients understand how the NeuroScience & TMS Treatment Center clinicians and the Nashville Center for Hope & Healing therapists work. Please read all the policies. In this document, the word "patient" refers to the person receiving care or the parent or guardian, when appropriate.

These policies are valid for all the NeuroScience & TMS Treatment Center locations as well as the Nashville Center for Hope & Healing therapy division. We may update our policies as may be necessary; continued use of our services after an update constitutes consent to the updated policies to the extent permitted by law.

(NeuroScience & TMS Treatment Center - Office Policies, updated 8-17-2023)

1. OFFICE APPOINTMENT & COMMUNICATION POLICIES

1.1. HOURS

Regular office hours are by appointment only.

1.2. ILLNESS

We have implemented an illness policy in the office to keep patients and their families, our families, and all employees and patients in our clinic free of illness.

Please notify us before coming into the offices if patients have any contagious illness, or have a fever, cough, or any shortness of breath. If patients have these symptoms or have been around anyone who has had a serious viral illness, patients should consider staying at home to avoid spreading the infection. We offer virtual visits for patient care if one can not attend an appointment in person.

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1.3. APPOINTMENT REMINDERS

As a courtesy, our electronic medical record provides appointment reminders via email or text as approved by the patient. In addition, our portal may have your appointment listed.

These reminders (electronic or phone or portal) are not guaranteed and not receiving a reminder is NOT a reason to avoid paying for a missed or canceled appointment. These reminders may be incorrect, for instance, if patients know that an appointment is scheduled as virtual and the reminder says the appointment is at the office, the appointment may still be virtual.

1.4. EXTENDED VISIT TIME

Physicians, Clinicians, and therapists in the office make efforts to see patients at their appointment time. Situations do arise where additional time is needed to address a specific need with someone; this extra time added to an appointment can cause a physician, clinician, or therapist to get behind in their schedule.

Extra time will be charged per our policies in SECTION 3.2.

1.5. COMMUNICATION WITH STAFF

Office staff employees typically answer virtual portal messages via MYIO portal, telephone calls, emails and text messages from 9 am to 4 pm, Monday through Friday. We do not ask our employees to work on Federal Holidays, but at times, the clinic may have appointments on these days.

If staff are assisting other patients OR if a patient calls after hours or during the lunch hour, the call will go directly to voicemail. Staff check and respond to voicemails regularly during office hours.

If considered appropriate by the clinician, telephone calls can be scheduled with prescribing clinicians and therapists and will be billed as virtual appointments.

If a patient has an emergency and needs to speak with a physician, clinician, or therapist during or after office hours, charges will apply, (see Section 3.8.4).

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1.5.1. MYIO PORTAL

Patients should register for the portal to submit messages to staff and their clinicians, request refills, or to change or request appointments.

1.5.2. HIPAA COMPLIANT TEXT LINE - 615.551.5853

We have a secure, HIPAA Compliant Text Line which patients, and potential patients can use to communicate with staff during their working hours, 9-4pm (Monday thru Friday), except federal or observed federal holidays). Generally staff do not communicate during the lunch hour (12 -1 PM).

Physicians, Clinicians & Therapists may send patient information from an appointment via this secure text line 615-551-5853; things that might be sent include: links for virtual visits, confirmation of refills, educational information or links. Our on-call clinicians may use a second text line 615-882-4480. Do NOT accept any other text lines regarding care from our clinic. The Clinicians & Therapists can access the Secure text line, but these clinicians and therapists do not monitor the text line; only staff monitor the text line.

The text line is not meant to be used as immediate access to a clinician or therapist.

The text line can not take the place of a visit with a Physician, Clinician or Therapist.

Important private information shared via this text line is shared with all staff and clinicians in the office.

Urgent or Emergent issues should be handled with a phone call or emergent page to the clinician on call.

As a potential patient or patient, please consider text messages, like emails to our office. This is another way to communicate with staff to reschedule appointments, schedule appointments, ask a non-clinical question, etc. All clinicians can see these communications and these communications can be included as part of the patient electronic medical record.

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1.5.3. EMAIL

We only use email from the domain name hopeforyourbrain.com, healnashville.com, or TMSworkbook.com. We use email for administrative purposes, like billing, receipts, scheduling, and patient feedback. Please DO NOT accept any emails from other domains regarding care from our clinic.

Patients, family members, and patients understand that using email has some inherent security risks.

Also to prevent email communication, notify our office in writing and do not supply an email to us, do not email us. If a patient originates an email to us, then they, therefore, give us permission to communicate with them via email.

Please do not use email for urgent or complicated issues that should be properly addressed via a consultation or at minimum a scheduled phone call to the office staff and provider.

If a patient emails clinical questions, staff will direct the concern to the physician, nurse practitioner, or therapist who is the primary treater. While a physician, clinician, or therapist may communicate the answer via staff within the day, generally 24 hours is necessary for them to respond to the inquiry. Physicians, Clinicians, and therapists responding to email may charge for their time, at a prorated hourly rate; this email communication with a physician, clinician, or therapist will likely be a non-insurance covered charge.

If the email concern is urgent or concerning (side effects from medications, serious behavioral problems or symptoms) tell the staff that there is need for an emergent or urgent phone call, or appointment.

1.6. VIRTUAL APPOINTMENTS

As of August 1, 2023, we have a secure HIPAA compliant Portal (MYIO portal) which all patients are expected to register on. This portal is where patients can access our virtual appointment links.

Our Physicians, clinicians, and therapists may communicate via a video or audio format like our MYIO virtual portal, doxy.me, Zoom, or audio, or another telephone line. A patient, who chooses to use this form of communication, agrees and understands that this form of communication has substantial and inherent security risks and hereby allows such communication.

These virtual appointments will be billed as face to face appointments. If a patient does not approve of this form of communication, then the patient must refuse such forms of communication and give us notification as such in writing. Face-to-face visits offer the only, more secure alternative to virtual visits.

Virtual appointments with clinicians must comply with state and local laws, and with the insurance coverage for the clinic. Patients will be required to be within Tennessee in order to be seen by a prescriber (psychiatrists, nurse practitioner). Most insurance companies cover charges for virtual visits in the same way that they do for face-to-face visits; check with the insurance policy that covers the patient's care for details. If patients fail to honor the Virtual appointment policy, an appointment could be terminated by the prescribing clinician. In this case, patients will be responsible for the full cost of the appointment; insurance will not cover these costs. THIS DOES NOT APPLY TO THERAPISTS. Because therapists are covered by different licensing boards and malpractice coverage, they are allowed to see patients who are not in Tennessee.

If patients have chosen to move outside of Tennessee, they will need to make sure that they will be in Tennessee for virtual appointments or come to see the physician, or clinician face to face, if patients intend to continue care in our office. If patients do not plan to return to our state, they will need to make arrangements to get prescriptions in the state where they are presently living.

1.7. SOCIAL MEDIA

Staff and professionals are encouraged to avoid personal virtual relationships via social media (e.g. Facebook, Snapchat, Instagram, LinkedIn) with patients.

Requests to friend a clinician will not be honored in order to respect professional boundaries.

1.8. TERMINATION

Our clinicians and patients may terminate services for any number of reasons. Some terminations of care, for example, patient failure to pay balances, or clinician and patient

differences in philosophy of care started by either the patient or the clinician are permanent, and patients may not return to our care.

Sometimes patients may transition to another clinician because of a move to a new city for work or school, and in these cases, patients may return to our care.

2. PRIVACY & CONFIDENTIALITY, RELEASE OF MEDICAL RECORDS, MINORS, AND OTHER SPECIAL POLICIES

Patient privacy and confidentiality will be respected at all levels of communication and is protected by the Federal and State Laws. There are, however, situations in which confidentiality may be compromised and the provider's professional and legal duty to protect may override the dictates of confidentiality. Briefly, these situations may include a strong indication of imminent danger to self or others or indication of abuse or neglect of another.

2.1. RELEASE OF INFORMATION

Following the execution of a valid Authorization for Release of Information, patient records, or a treatment summary will be forwarded to licensed professionals at no charge as a professional courtesy.

While all patients are entitled to their medical records, requests to release mental health protected private records to any other entity (including attorneys, underwriting companies, etc. including copies to the patient themself) will be billed at the actual cost of supplying the records, to include cost of physician, clinician, or therapist and staff time to review, copy, mail, and any additional professional time. When a request for records is received staff will check with the clinician who is treating the patient to determine if the request is valid. If there are concerns, someone will reach out to the patient to verify.

Any request for release of records must allow at least three weeks preparation time. The typical charge for a copy of a patient's medical records is $50. Should the patient want to review their entire medical record, this can be done together, in person, in an office appointment; charges for the office appointment apply.

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2.2. ADOLESCENTS AND CHILDREN OR THOSE WITH A LEGAL GUARDIAN

Patients under the age of 18 require consent from a parent or legal guardians to receive medical services. Please discuss the concerns about the limits of confidentiality with the physician, clinician, or therapist overseeing care, and read the Privacy (HIPAA) statement on our website, or on file at the office.

With all minors, or wards, we must legally have at least one (1) parent/guardian present in the office during the first appointment, and subsequent appointments unless otherwise discussed with the clinician. The interview will include the parent for a portion of the time, but we will also take some time to see the patient alone. Any testing or available I.E.P. should be brought to the session or provided prior to the session for review.

If parents are divorced, both can attend if they choose; it is expected that divorced parents will maintain calm conversation focused on the patient. If it is a volatile situation between parents, it is better for one (1) parent to attend and the other to write a letter describing their observations and concerns for the child. If divorced parents do not communicate well, we alternatively suggest that the non-attending parent schedule a meeting with providers either in-person or by phone after the initial evaluation is complete. This encounter will be billed as either a consultation with a family member or as a regular session depending on the time required and whether it is in-person or virtual. It is acceptable for the child to attend that meeting, or not.

2.3. SPECIAL TESTS OR PROCEDURES, RESULTS - Labs, Urine Drug Screening, Pharmacogenetic Testing

Most lab results will be reviewed with the patient at the next scheduled visit, (unless there is a more pressing need prior to the visit). A small clinical charge may be charged to review the laboratory values when the results arrive in our office.

The patient will be charged based on the clinician's time utilized at the clinician's discretion per their prorated hourly charge. In most cases, clinicians will attempt to wait and review the information during the next patient appointment.

In some cases, because an appointment may not be scheduled for a significant time after the lab results return, clinicians may decide to communicate the results to the patient before the next appointment. These results can be sent via email, secure text, fax, and mail.

Urine Drug Screening and Pharmacogenetic Testing may be medically necessary for some patient's care or treatment in the office. Laboratory collection fees may apply if we are collecting and processing the specimen; a $30 fee to collect, process and record the laboratory results will apply.

2.4. CONTROLLED SUBSTANCE MEDICATIONS

Medications called controlled substances are indicated in some psychiatric illnesses and may be used by a clinician at the NeuroScience & TMS Treatment Center for a patient's treatment.

Shortages of controlled substance medications used for Attention Deficit disorder and other conditions do occur. This is not a problem that our office can fix. Sometimes a local and even a national shortage can occur. As we can not keep track of individual pharmacy stock and because these medications are controlled by federal and local agencies, it is best if the prescription is maintained at the pharmacy to which it was sent.

We understand that it can be scary not having medication, but not having a stimulant will not cause dangerous symptoms. Pharmacists are able to transfer a controlled substance script one time if they do not have the stock.

Only in dire situations will a prescriber switch pharmacies once an electronic prescription for a controlled substance is submitted to the pharmacy. Because this process of switching a controlled substance is complicated, please note that patients may incur a prescription refill outside of an office visit charge for changes to a pharmacy (up to $50). Prescribers will determine this on a case by case basis.

There are effective non-controlled medications for ADHD that can be used for patients as an alternative to stimulants.

Controlled substances can have an increased risk of dependence and/or addiction for some people, therefore it is expected that each patient prescribed this medication will review and sign a controlled substance agreement. Patients should not vary the dosage, nor interval of these medications without authorization.

Failure to follow the agreement guideline, may result in my treatment being terminated.

2.5. PRESCRIBING MEDICATIONS

Ideally, medication is prescribed in office visits (face to face or virtually) after an evaluation of the patient's symptoms. Our licensed prescribing physicians and nurse practitioners may only prescribe medications in the states which they are licensed. Medications can not be prescribed in states where they do not hold an active medical license.

2.6. DEPOSITION POLICY

Please contact our office directly if a deposition is necessary. We have a specific policy on depositions for patients or former patients.

3. PAYMENT AND CHARGE POLICIES

3.1. DEPOSIT PAYMENT

A deposit payment for the initial appointment is due prior to any scheduling.

The deposit is used to hold a visit in the office and will be applied toward any office charges.

If the clinician is in-network with the patient's insurance, we apply the deposit to the co-pay, co-insurance, and/or deductible. The deposit will probably not cover the entire patient cost for the appointment, but if the deposit does cover all the patient cost, then any amount remaining can be refunded to the patient or payer or kept in the clinic for future visits.

If the clinician is out-of-network, or the patient does not have insurance, the patient or the parent/guardian will owe the remaining cost of the appointment.

3.2. PAYMENT FOR APPOINTMENT & SERVICES

Payment of copays, coinsurance, and deductibles are due at the time of service, regardless of payment expectations with in-network insurance

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3.2.1. IN-NETWORK INSURANCE

The contract with an insurance company to pay for any portion of patient medical care is between the patient and the patient insurance company. Many of our physicians, and clinicians are "in-network" with insurance companies; this means that they have contracted to accept a negotiated rate from the insurance company.

We strive to have all the physicians and clinicians in our clinic contracted with the following insurance companies, *this does not apply to the therapists:*

- *Blue Cross Blue Shield*
- *Anthem*
- *United Healthcare/ OPTUM/ Choice Plus*
- *UMR*
- *Aetna*
- *Cigna*

The clinic files insurance claims for in-network insurance only. If the patient provides accurate insurance information (policy number, group number, subscriber name, Date of birth and address) and the patient is covered, we will file in-network claims and follow up on reimbursement.

If we are in-network with an insurance company and are contractually required to obtain authorization for care (like TMS or Spraavato), we will attempt to obtain prior authorization. As some insurance companies deny coverage even when prior authorization criteria are met; if a patient wants to start any of these treatments prior to authorization being received, a special financial agreement document will need to be completed.

If the patient 1) certifies that they have insurance coverage, 2) assigns all insurance benefits directly to the clinic, and 3) sees a physician or clinician who is a contracted provider with the insurance, then we will file the insurance claims. It is the patient's obligation to pay the copay, deductible, and any co-insurance due. If the patient's insurance company fails to reimburse because of non-coverage, the Patient is still financially responsible for all charges. The Patient, hereby, authorizes the NeuroScience & TMS Treatment Center to release all information necessary to secure the payment of benefits. The Patient authorizes the use of this signature on all insurance submissions.

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Rarely, a patient may have an insurance card that is one that a clinician is in network with but the patient's coverage is actually managed by a third party administrator or another carve-out entity for behavioral health benefits that we may not be contracted with as "in-network." If the insurance claim processes as out-of-network, the patient will be financially responsible for the out of network/self pay rate for those appointments.

3.2.2. OUT OF NETWORK

We can provide a statement of service (SOS) to the patient for reimbursement out-of-network, but the patient will have to submit this form to their insurance company. We cannot do this, and do not guarantee out-of-network insurance reimbursement of any kind.

We recommend that patients contact their insurance carrier and request instructions for filing claims. It is the Patient's responsibility to obtain all referrals/authorizations required by out-of-network insurance plans.

Patients must follow up with their insurance to understand how out of network claims will be reimbursed. The Patient or responsible party is responsible to check with their insurance plan from time to time to ensure claims are being properly processed.

Patients can request a statement of service with all the codes necessary to file a claim with an insurance company by emailing billing@hopeforyourbrain.com.

3.2.3. GOVERNMENT SPONSORED INSURANCE (MEDICARE, MEDICAID, OR TENNCARE)

The Physicians, Clinicians, and therapists at our clinic do not accept Medicare, Medicaid, or TennCare for office services. Some have chosen not to enroll, some have chosen to terminate their Medicare contracts, others have opted out of the contracts, and finally a few have specific agreements with the hospitals they work within to care for patients with these government sponsored insurance plans but can not see patients in the office with these plans.

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All patients who have Medicare insurance policies (eligible for Medicare) must note that our clinic may not file a claim to Medicare, Medicaid, nor TennCare for reimbursement of the cost of medical services. Government-Sponsored insurance plans may require and stipulate physicians, nurse practitioners, therapists, and other clinicians to practice with specific medication formularies, and specific treatment protocols.

If a patient has these government sponsored plans, they do not have to receive care in our clinic, they can receive care by other healthcare physicians & clinicians who accept and work with these plans.

Finally, Medicare usually requires that Opted-out providers or Non-Medicare providers enter into a private contract with patients in compliance with 42 U.S.C. §1395a; 42 C.F.R. § 405, subpart D. As we are NOT Medicare providers, have not been excluded, and have not entered into a contract with Medicare, we will not ask a patient to enter into a private contract. Patients may file the claims to these plans themselves following a visit in our office; for Medicare one can file using form 1490 S which can be obtained via the company that manages the government Medicare insurance benefits. Patients may be reimbursed directly for the portion Medicare would have paid an in-network Medicare provider; but it is important that Patients understand that it is equally likely that these plans likely will not cover the healthcare charges for appointments in our office, and may not cover medications, or any diagnostic workup recommended by our physicians, clinicians, or therapists (for example: tests, labs, MRIs ordered). Again, we cannot file the claim for patients, as we are not contracted with these companies.

3.3. BILLING DISPUTE

If a patient receives a charge which they believe to be invalid, our office will accept *a written notice concerning the disputed charge*. We will review the dispute with supporting evidence and respond in a timely manner.

3.4. CHARGES FOR SPECIFIC OFFICE VISITS or ASSESSMENTS

The CHARGES for office visits are listed below. *These are private pay rates for patients that do not have insurance*.

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If the clinicians seen are in-network with the insurance company that covers the patient, the office will file charges with the insurance and reductions may be granted based upon the allowed amounts of the in our negotiated contract.

Each individual insurance has a specific contracted rate with us, so our office can not determine the final dollar amount, specifically, a patient will pay for the visit prior to coming to the office.

Each individual office has an assortment of different codes that the clinicians might use and sometimes we will add codes based upon special assessments we might do if they are medically relevant. Patients may have a copay, co-insurance and deductible for each charge. There could be occasions when the insurance charges will exceed these private pay rates.

COMPREHENSIVE TEAM EVALUATIONS - private pay rates

$745 Comprehensive Team Evaluation with Physician & Therapist (45-60 min with therapist, assessments and then 45- 60 min with a Physician, and 30 min for Records review)

$645 Comprehensive Team Evaluation with Psychiatric Nurse Practitioner & Therapist (45-60 min with therapist, assessments and then 45- 60 min with a Psychiatric Nurse Practitioner)

PHYSICIAN APPOINTMENTS

$495 New Patient Consultation Evaluation with a Physician (60 minutes face to face, 30 minutes for records review)

$350 for an Interventional Consultation (TMS, Spravato, VNS, ECT, or similar) with a Prescribing Clinician - Physician (60 minutes face to face, 30 minutes for records review); *this is not a complete evaluation, but a specific interventional consultation*

$375 for an hour follow-up session with a Physician

$250 for a 20–30-minute follow-up session with a Physician

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PSYCHIATRIC MENTAL HEALTH NURSE PRACTITIONER APPOINTMENTS

$395 New Patient Evaluation with a Psychiatric Nurse Practitioner (60 minutes face to face, 30 minutes for records review)

$250 for an hour session with a Psychiatric Nurse Practitioner

$150 for a 20–30-minute follow-up with a Psychiatric Nurse Practitioner

THERAPIST APPOINTMENTS

$250 New Patient Evaluation with Therapist (75-90 minutes)

$175 for Follow-up Appointment with Therapist (60 minutes)

$155 for Follow-up with Therapist*, (45 minutes)

$100 Follow up with Therapist*, (30 minutes)
**for couples or families there is $20 additional charge*

OTHER POTENTIAL CHARGES

$50 to $250 Assessments, as may be medically necessary
$50 Refills outside of office visits, see description Section 3.11.2 of Policies below
$50 Insufficient funds charge, see description Section 3.8 of Policies below

TMS & Esketamine patients will be given a separate specific financial estimate & agreement based upon their insurance plan contracts

3.5. EXTENDED VISIT CHARGES

Physicians, Clinicians, and therapists can extend a patient's scheduled time, and if the appointment goes beyond the originally booked time, the Physician, Clinician, or therapist will bill for the additional time in session. This extra time may be billable to a patient's insurance company if the clinician is in-network, but the charge may be considered a non-insurance covered charge, particularly if a patient is seeing a therapist in the clinic.

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Talk to the Physician, Clinician, and therapist specifically if there is a concern about additional charges.

3.6. CREDIT CARD FOR OUTSTANDING BALANCE GUARANTEE

We expect that patients will provide our clinic with a credit card number on our portal which will be kept on file with our secure vendor. This card will be used to charge the deposit, and any outstanding balances or non-covered charges which are incurred.

While the majority of patient fees are paid for at the time of service, some charges like emergency calls, prescription refills outside an appointment, no show charges, record reviews, letters, consultations with outside providers, bounced checks, etc., as an example, may occur when the patient is not available to pay.

In the event the patient incurs any charge at any time or if insurance declares a service is not covered, non-eligible, or not necessary, the patient is responsible to pay for the charges as published. The patient will be asked at the time of enrollment to authorize our office to charge the patient's or responsible parties credit card on file for the total amount outstanding. The patient can request that another form of payment be used for these outstanding charges.

3.7. FINANCING

We do not have payment plans or financing options internally. We recommend using a credit card to finance payments to us if needed.

3.8. INSUFFICIENT FUNDS

The Patient agrees and understands that the Not Sufficient Funds (NSF) Fee ($50) will be added to the Patient's account for any "bounced" check.

3.9. INTEREST CHARGES

The Patient agrees and understands that any outstanding balance over 60 days is subject to the highest interest rate allowed by law in the State of Tennessee.

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3.10. OTHER NON-INSURANCE COVERED CHARGES

An insurance plan may determine that a service(s) provided by our physician, clinician, or therapist is not a Covered Service, an Investigational Service, or the service is not considered to be Medically Necessary or Medically Appropriate. If an insurance plan makes this determination, then the Patient will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges, and any other related expenses. The Patient acknowledges that his/her insurance plan may not pay for these non-covered charges or service(s) or treatment(s) and the patient would be responsible for these.

Patient's have the right to request reconsideration of that determination by their insurance company, as is often described in the Member grievance section of one's health care benefits plan. If the patient wants the Physician, clinician, or therapist to file an appeal or grievance, the patient may have to appoint our office as the person(s) doing this appeal or grievance.

The Patient understands that the Physician, clinician, or therapist may also request that the Patient's insurance plan reconsider that determination by presenting further evidence that the referenced service(s) should be covered.

3.10.1. LATE CANCELLATIONS OR MISSED APPOINTMENTS

Our physicians, nurse practitioners, and therapists are highly regarded because we work hard to get patients well. Most of their days are booked in order to help the most patients they can.
We have a 72-hour (three business-day) cancellation policy for all appointments. If a patient misses a scheduled appointment, they will be billed for the appointment. If the patient does not cancel within the notice period, the patient will be obligated to pay the full fee of the service. This cancellation policy includes virtual visits.

The Notice Period is 72 hours or 3 business days. The notice to cancel an appointment must be received by 4:00 pm to be counted on that business day. The late cancellation fee or missed appointment fee is not billable to insurance.

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3.10.2. PAPERWORK OUTSIDE OF OFFICE VISITS

Our clinic charges for paperwork services as it takes valuable clinician time to complete the tasks or services. Forms which patients may want or need, take time to correctly complete. Charges for paperwork are billed at the rate of $50 per 10 minutes.

Some paperwork does not have a fee:

- Simple Work and/or School Excuses, those that note that a visit occurred, can be produced by staff after an appointment.
- Paperwork to coordinate care, notes which are authorized to be sent to other treating clinicians or therapists.

Some paperwork has a fee, a charge which must be paid

- Prior authorizations for medication which are completed outside of an office visit; our clinicians may prescribe necessary medication that is believed to be the best care based upon their medical expertise, a patient's insurance company may still deny the medication or treatment because of its cost.
- Insurance Appeals which are completed outside of an office visit, and which are excessive for medically necessary services which we have prescribed.
- Life and Disability Paperwork which is completed outside of an office visit.
- FMLA paperwork or similar paperwork that is completed outside of an office visit.
- Prescribers and Therapists may charge for long letters or summaries to collaborating care, reviewing other records, as it pertains to diagnosis and treatment.
- Electronic Communications such as texts or emails which were requested instead of an office visit may be charged if they require medical consideration or medical decision making which must be documented; Physicians, Clinicians, and therapists prefer to have a visit (face to face or virtual) to care for patients instead of Electronic Communications.

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3.10.3. PRESCRIPTION REFILLS OUTSIDE OF A SCHEDULED VISIT

The office policy is to have all medication prescribed within a scheduled appointment when an assessment can be made of the patient; prescribing clinicians, generally, do not prescribe medication outside office visits.

If a patient is prescribed medication, they will be given enough medication through the next scheduled appointment. If the appointment is rescheduled because of unforeseen circumstances, contact the office staff to arrange for medication refills. We will not charge for a refill if we rescheduled and caused a patient to run out of medications. If a patient cancels an appointment, it is advised to reschedule quickly to avoid running out of medication.

Please Do NOT wait until prescription bottles are empty or refills are expired, to request a refill.

Contact us directly, not via the pharmacy, if the patient needs a refill of prescribed medication, please allow 72 hours (3 business days) for a refill to be sent.

If patient's are out of medication and are receiving care from a clinician in our clinic, patient's may urgently notify staff or the on-call prescriber. Urgent or Emergency charges may apply.

Medication refills are handled during office hours.

Prescription refills outside of an office visit will be charged at the prescribing clinician's prorated charge for the time it takes to contact the pharmacy, review the file, document the refill, and if appropriate, check the State Controlled Substance database. This process can take 15 or more minutes of the prescriber's time.

The standard charge for a Prescription Refill outside of an office visit is $50, the charge may be higher if multiple pharmacy changes are necessary or a significantly complicated situation occurs that is unexpected. This fee is not billable to healthcare insurance companies.

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3.10.4. EMERGENCY CALL OR URGENT CALL CHARGES

Emergency Calls On-Call Physician or Clinician office line with service by the on-call clinician will be charged to the patient; this fee is approximately $100 per 10 minutes for a phone call or video session when completed as an emergency outside a scheduled appointment.

*The on-call clinician *may* be able to bill insurance for the emergency call if the service is available in our in-network insurance contract, in this case, the on-call clinician will make an effort to bill accordingly. In most cases, emergent or urgent charges are not covered by insurance.

4. OTHER POLICIES

Every scenario can not be predicted. If a concern arises that we do not have a policy to cover, our Chief Medical Officer and the physician, clinician, or therapist involved will work together to consider all options.