Redwood PsychAlliance, Inc.

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	Sex:	DOB:
			❑ Male ❑ Female	/ /

Social Security No.:	Home Phone Number:	Cell Phone Number:
_ _	( )	( )

Address:

P.O. Box:	City:	State:	ZIP Code:

Mother: (if minor)	Father: (if minor)
Do you want appointment reminders? ❑ YES or ❑ NO	Would you like a reminder by : ❑ Email ❑ Phone ❑ Both

Email Address: (for appointment reminders only):

Preferred Pharmacy Name: **Pharmacy Address:**

INSURANCE INFORMATION

Do you have any Medicare or Medi-Cal Insurance Coverage? ❑ YES ❑ No **(WE DO NOT SUBMIT/CONTRACT FOR EITHER)**

Person responsible for bill:	Birth Date: / /	Address (if different):	Home Phone Number: ( )

Cell phone no.: ( ) **Work phone no.: ( )**

Is this patient covered by insurance? ❑ Yes ❑ No

Name of Insurance Co.: **Insurance Telephone No.:** ( )

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other

IN CASE OF EMERGENCY

Name	Relationship to patient:	Home Phone Number: ( )	Cell Phone Number: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician/clinician. I understand that I am financially responsible for any balance. I also authorize Redwood PsychAlliance, Inc. or Insurance Company to release any information required to process my claims.

Patient/Guardian Signature **Date**

Redwood PsychAlliance, Inc.

2200 Range Avenue, Suite 200 ● Santa Rosa, CA 95403-9473
(T) 707.568.1101 / (F) 707.568.1103

TREATMENT AGREEMENT WITH LORETTE LABATAILLE, MD

Redwood PsychAlliance (RPA, Inc.) does not provide psychiatric crisis management outside of office hours. If immediate stabilization of treatment of a psychiatric emergency is needed, **call 911**, Sonoma County Psychiatric Emergency Services (707) 576-8181 or go to (Sonoma County Psychiatric Emergency Services at 3322 Chanate Road in Santa Rosa) or go to the nearest emergency room or hospital.

SERVICES PROVIDED

Dr. Labataille provides psychiatric outpatient treatment and medication management for adults 18 years and older. She can be reached Monday through Thursday from 9am until 5pm by calling the office at (707) 568-1101 and speaking with the staff or leaving a message call (707) 58-1101 dial her extension 106. If there is an emergency after hours or weekends, which includes Fridays, you may reach her at (415) 847-6751.

PAYMENT

Copays and deductibles are the patients' responsibility and **are due at the time of service**. Forms of payments excepted are cash, check, credit/debit cards. If you cannot make your copayment or deductible payment, we may require that you re-schedule your appointment.
If there is an outstanding balance we require that the payment be made prior to scheduling any further appointments.

CONTRACTED INSURANCE CARRIERS

Redwood PsychAlliance currently direct bills only the following Insurance Companies for Dr. Labataille: Aetna, Anthem Blue Cross and Blue Shield of California. She does not bill for Medicare nor Medical.
It is the patient or guardians' responsibility to notify RPA of any changes to the insurance. It is best to know your insurance benefits for Outpatient Mental Health. Your plan may require you to obtain an authorization for treatment prior to an appointment. If your plan does require an authorization and you do not get one you may be responsible for the full fee of the appointment with the provider due to non-payment from the insurance company.

CANCELLATIONS/ RE-SCHEDULE/MISSED APPOINTMENT

An appointment time has been set aside for you. If you **miss, cancel or reschedule an appointment you will be charged a fee of $120**. This is not a billable charge to the insurance company, but the responsibility of the patient. Cancellations must be made **at least 24 hours prior to the scheduled appointment time**, during normal business hours Monday through Thursday from 9am to 5pm, if the appointment is on a Monday cancellation should be no later than Thursday by 3pm.

MEDICATION REFILLS **PLAN AHEAD**: **Requests for medications refills may take up to 5-7 business days.**
It is your responsibility to keep track of your medication(s).

It is best to make sure you have enough medication until your next appointment. If you require a paper prescription before your next appointment you may be charged a prescription fee per paper prescription.

1. Refill requests must be made through your pharmacy. Please have your pharmacy fax us a refill request to (707) 568-1103.
2. For controlled substance medications, the patient may be required to be seen in the office at Dr. Labataille's discretion for a medication review.
3. Controlled medications cannot be mailed or called into the pharmacy.
4. Do not contact Dr. Labataille after hours or on her emergency number for a prescription refill, this is not an emergency.

VOICEMAIL POLICY

Non urgent calls will usually be answered within 48 hours. Please do not call her emergency numbers during office hours. When leaving a message please call (707) 568-1101 ext. 106 Speak clearly and leave a confidential or private number for a return call or voicemail.

OTHER SERVICES

Dr. Labataille will provide forms, letters and reports to outside sources with your authorization. These forms, letters and reports take time and effort to produce. You will be required to have an appointment for this service. There will be a minimum charge of $10 to produce these document(s) we will inform you of the fee prior to writing these documents.

TERMINATION OR TRANSFER OF CARE

Healthy terminations and transition to another care provider may be a goal and part of treatment. These changes need to be discussed in person with Dr. Labataille. Records can be faxed or copied for a fee upon written request.

CONFIDENTAILITY POLICY

Your confidentiality and privacy are of the utmost importance. Any information about you will be shared with others (including family members) **ONLY** with your written consent. The only exceptions to this are when the following legal limitations apply:

1. When the patient communicates threat of bodily injury to self or others
2. When the patient communicated that he/she is the victim of abuse by another
3. When there is reasonable suspicion of child abuse or abuse to a dependent adult has or will occur
4. When information is required by law or ordered by the court
5. When information is released by you for your insurance provider

At times, I receive professional consultation. At these times, neither your name nor any identifying information is revealed.

I, _____have read, understand and agree to abide by the terms of the treatment contract outlined above.

PRINT NAME

SIGNATURE:_____DATE:_____

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MISSED / NO SHOW / LATE CANCELATION POLICY

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT(S).

I understand and agree to the following:

(1) It is my responsibility to notify my provider at Redwood PsychAlliance, Inc., 24 hours prior to the scheduled appointment time, if I am unable to keep the scheduled appointment.

(2) Cancelations must be made at least **24 hours prior** to appointment. During normal business hours Monday through Thursday from 9am until 4pm (PST). If the appointment is on a Monday cancelation should be no later than 4pm (PST) on Thursday.

(3) I agree that I will be billed the **full** fee in the event that I/ or my child miss an appointment or fail to cancel 24 hours prior to the scheduled appointment.

The full fee as follows:

MD: $120
LMFT: $60

_____ _____

PATIENT NAME (PRINT) **REPRESENTATIVE/ PARENT OR GUARDIAN (IF MINOR) (PRINT)**

_____ _____

PATIENT SIGNATURE **REPRESENTATIVE/ PARENT OR GUARDIAN SIGNATURE**

_____

DATE

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MEDICATION POLICY

Controlled Medication(s)
This type of medication requires that you are seen in the office for an appointment and **CANNOT** be called or faxed into the pharmacies. If you do run out of this type of medication before your next scheduled appointment and your physician has to write a prescription, you may be charged a $10 prescription fee at the time of pick up at the providers' discretion.

Refills
You are required to contact our office or your pharmacy at least 5-7 business days for a refill request. The pharmacy may fax the request to (707) 568-1103. You may also call our office and leave a message at (707) 568-1101 ext.109.

Mail Order Prescriptions
Redwood PsychAlliance, Inc. would like to assist you in benefiting from mail order prescription services as long as it does not interfere with the quality of your care. For this reason, we will expect you to keep the recommended appointments scheduled by your physician, in order for your psychiatrist to provide a 90 day prescription.

About Your Prescriptions and Visits
The relationship between the psychiatrist and his/her patient is a partnership, the goal of which is the well-being of the patient's mental health. Although regularly scheduled visits with your psychiatrist may at times feel burdensome,
Redwood PsychAlliance, Inc. has the following procedures in place as we have found that they ensure that you or your child will receive the highest quality of care.

- Always discuss any changes or side effects in medications with your psychiatrist.
- Never stop or change the dose of a medication without contacting your psychiatrist.
- When medications are stopped, they must either be stopped gradually or be replaced with another more effective medication prescribed by your psychiatrists.
- Suddenly stopping medication can cause medical problems. For this reason, never allow yourself to run out of medication.
- Be sure to keep your appointments. Although your psychiatrist will provide you with adequate medication until your next visit, cancelled or missed visits can prevent you from having an adequate supply of medication and makes it difficult for your psychiatrist to properly monitor your progress and help with complications.
- If you do cancel or miss a visit, be sure to reschedule your next visit before you run out of medication.
- For your safety most medication changes are not done over the phone.
- If side-effects or problems occur with your medication, contact our office to arrange an urgent visit with your psychiatrist.

_____
PATIENT NAME

_____
PATIENT SIGNATURE/ PARENT OR GUARDIAN (IF MINOR)

_____
DATE

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Acknowledgement of Receipt of Notice of Privacy Practice

The HIPPA is posted on the website and in the waiting room.

I, _____, have received a copy of Redwood PsychAlliance, Inc. Notice of Privacy Practices.

_____ _____

PATENT NAME (PRINT) **RESPONSIBLE PARTY/PARENT OR GUARDIAN (IF MINOR)**

_____ _____

PATIENT SIGNATURE **RESPONSIBLE PARTY/ PARENT OR GUARDIAN SIGNATURE (IF MINOR)**

_____

DATE

IT IS YOUR RIGHT TO REFUSE TO SIGN THIS DOCUMENT

FOR OFFICE USE ONLY:

The reason that a standard acknowledgement if the receipt of the Notice of Privacy Practices was not obtained:

□ Patient/ Representative/ Parent or Guardian refused to sign

□ Communication barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented this office from obtaining it

□ Other: _____

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SIGNATURE ON FILE

(PLEASE INITIAL EACH BOX)

☐ I authorize the doctor or clinician to use my name on any and all claims or documents that relate to health insurance benefits due to me and my dependents.

☐ I authorize release of any information related to any claims to all my insurance companies or other relevant parties.

☐ I understand that I am responsible for my bill and agree to pay all charges for services and items provided to me.

☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance companies.

☐ I authorize payment of health benefits otherwise payable to me, directly to my doctor/clinician.

☐ I permit a copy of this authorization to be used in place of the original.

☐ This "Signature on File" is valid for one year from the dated indicted below.

_____

NAME OF PATIENT (PRINT)

_____

SIGNATURE OF PATIENT /REPRESENTATIVE OR LEGAL GUARDIAN (IF MINOR)

_____

DATE

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FEE SCHEDULE

INITIAL EVALUATION / ADULT: (Non Insurance)
$350 (MD)
$150 (LMFT)

INITIAL EVALUATION / CHILD: (Non Insurance)
$200 (Parent(s) w/ MD)
$350 (Child w/ MD)
$150 (LMFT)

FOLLOW UP (60 MINUTES): (Non Insurance)
$200 (MD)
$120 (LMFT)

FOLLOW UP (30 MINUTES): (Non Insurance)
$150 (MD)

LATE CANCELATION / MISSED / NO SHOW APPOINTMENT FEE:
$120 (MD)
$60 (LMFT)

PRESCRIPTIONS (NON APPOINTMENT):
$10

REPORT/ FORMS/LETTER(S):
$10 minimum @ Provider's discretion

RECORDS:
$25 minimum (.10¢ per page after 20 pages)

INSUFFICIENT FUNDS:
$25 per check returned to Redwood PsychAlliance, Inc.

_____ _____

Patient Name (PRINT) **Responsible Party/Parent/Guardian (If Minor) (PRINT)**

_____ _____

Patient Signature **Parent/Guardian Signature (If Minor)**

_____

DATE

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FINANCIAL AGREEMENT

REGARDING INSURANCE ASSIGNMENT:

- We will only file claims with insurance companies we are contracted with. In order to achieve this, we must have all current insurance information on file.
- If there are any changes in your insurance coverage, you must notify Redwood PsychAlliance, Inc. prior to your next appointment**.**
- The patient must stay current with the payment of their deductibles and co-payments. All information this office gives in reference to your insurance coverage is based on information obtained from your insurance company. It is only descriptive of your benefits, and is not a guarantee of payment by your insurance company. An insurance company may quote benefits and give authorization, but clearly state in their disclaimer this is not a guarantee of payment. Therefore, any amount we collect at the time of service or quote as your responsibility is any estimate only. You are ultimately responsible for any and all balances on your account.

The patient receiving treatment from Redwood PsychAlliance, Inc. agrees to: (PLEASE INITIAL EACH BOX)

☐ I AM RESPONSIBLE FOR ALL EXPENSES INVOLVING MY TREATMENT.

☐ PAYMENT OF CHARGES IS DUE AT THE TIME OF THE APPOINTMENT BY CASH, CHECK OR CREDIT/DEBIT CARD.

☐ IF REDWOOD PSYCHALLIANCE, INC. FILES CLAIMS ON MY BEHALF, I AGREE TO PAY FOR NON-COVERED INSURANCE BENEFITS, CO-INSURANCE AND DEDUCTIBLES.

☐ IF MY MINOR CHILD IS BEING TREATED I AM REQUIRED TO SEND PAYMENT IN **AT THE TIME OF SERVICE OR HAVE A CURRENT CREDIT CARD ON FILE.**

☐ I GIVE REDWOOD PSYCHALLIANCE, INC. PERMISSION TO USE MY CREDIT CARD ON FILE FOR ANY CHARGES DUE ON MY ACCOUNT.

CREDIT CARD:	
CREDIT CARD #:	
CREDIT CARD EXP:	
NAME ON C/C:	
BILLING ADDRESS:	

_____ _____

Patient Name (PRINT) **Responsible Party Name (PRINT) (Parent/Guardian of Minor)**

_____ _____

Patient Signature **Parent/Guardian Signature (If Minor)**

_____

DATE