PATIENT INFORMATION

Today's Date_____

Name_____ Age _____

Preferred Name_____ DOB_____Male/Female

Address_____City_____State _____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____

Primary Care Physician _____

PLEASE FILL OUT PARENT/GUARDIAN SECTION IF THE PATIENT IS A CHILD:

Parent/ Guardian Name_____DOB _____

Address_____City_____State _____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____

Parent/ Guardian Name_____DOB _____

Address_____City_____State _____Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email _____

Name of Person Responsible for this account _____

Emergency Contact Name_____Phone_____Relationship_____

Emergency Contact Name_____Phone_____Relationship_____

Insurance Information

Name of Policy Holder:_____DOB _____

Primary Insurance Company_____Member ID _____

Group #_____Relationship to Patient _____

Name of Policy Holder:_____DOB _____

Secondary Insurance Company_____Member ID_____

Group #_____Relationship to Patient _____

Susan Balk Kradel, M.D.
and Associates, P. A.
Child, Adolescent, and Adult Psychiatry

1000 W. 11th Street
(850)913-8313

Panama City, FL 32401
Fax: (850) 913-8314

CONSENT FOR TREATMENT: *I seek treatment and wish to take part in treatment by Dr. Balk. I agree to assist in developing a treatment plan and regularly reviewing progress toward meeting the goals of the treatment plan with the doctor. I agree to take an active role in this process.*

PROFESSIONAL FEES: *I understand that all fees for treatment services are charged to the patient. I am responsible for the treatment fees, regardless of insurance. I understand that payment is due when services are provided. I agree to provide updated information about my address and insurance, if these change.*

AUTHORIZATIONS: *I authorize release of medical records to the insurance company, if required for payment of services. This may include information about the type, cost, dates and providers of services. I understand that if any third party payer does not fulfill my financial obligations, I am responsible.*

TERMINATION OF TREATMENT: *I am aware that I may stop treatment with Dr. Balk at any time. If treatment is ended, I am responsible only for payment of services already provided by Dr. Balk. I also understand that Dr. Balk may terminate treatment services to me. If this occurs she or her office will refer me to other provider(s) in the area.*

APPOINTMENTS: *I agree to cancel scheduled appointments 24 hours in advance. I understand that a parent or guardian must accompany any minor child to appointments.*

I state that the information provided is correct. I understand and agree with the provisions above. I understand that this information is confidential.

Patient's Signature (or Guardian) *Date*

Printed Name *Relationship to Patient*

I, Susan Balk Kradel, M.D. have discussed the issues above with the patient/guardian. I believe this person is competent to give informed and willing consent.

Susan Balk Kradel, M.D. *Date*

BOTH SIDES

Susan Balk Kradel, MD and Associates PA
Financial Statement and Policies

Payment for professional services is due at the time of the appointment. Cash, check, and credit cards are accepted. We will gladly provide an insurance claim form to you when your session is fully paid, so that you may file your own insurance for reimbursement. Insurance payment or non-payment is between you and your insurance company.

Some insurance companies will require a prior authorization from our office. We will make every attempt to secure this information from your insurance company prior to the session. Prior authorization and verification of your insurance does not guarantee insurance payment for services rendered. Ultimately, responsibility for payment for services rests with the patient/guardian.

A statement of account will be sent monthly for three months if a balance should remain unpaid. If after 90 days from the date of service, the account remains delinquent, the account will be reviewed and turned over to a collection agency. Treatment may be terminated due to failure to maintain payment on an account.

I, the undersigned, have read and understand the policies noted above. I accept full financial responsibility for the provided services.

_____ *Patient*

_____ *Patient's DOB*

_____ *Patient/Guardian's Signature*

_____ *Date*

Telephone Call Policy

Calls to the office regarding clinical emergencies are always appropriate and will be returned as quickly as possible. During working hours, staff will document an emergency call and notify Dr. Balk promptly. After working hours, the answering service will text message Dr. Balk regarding an emergency call.

Occasionally patients or families request telephone contact with Dr. Balk to discuss non-emergent treatment issues between appointments. Typically these calls are returned at the end of the day, so that they do not interrupt other patients' scheduled appointments. These calls essentially constitute treatment over the phone. For that reason, such calls incur a charge to the patient, based on the length of the phone call.

Electronic Prescription Policy

For your convenience, this office has instituted use of electronic prescriptions. We will gladly send most prescriptions to your local or mail-order pharmacy electronically, whenever possible. This simplifies and speeds the processing of the prescription. By law we can NOT submit some prescriptions electronically, such as stimulant medications. These require an actual paper prescription to be delivered to the pharmacist.

With your consent, we can review all prescriptions that have been submitted to your pharmacy, even by other providers, to ensure no duplications or adverse interactions.

Scheduling of Appointments

Most Pre-Treatment Appointments are scheduled for 30-40 minutes. The initial "New Patient" appointment is one hour. Routine "follow-up" appointments are scheduled for approximately 15 minutes. Occasionally a longer follow-up appointment is required to discuss very serious or complicated treatment issues. Please keep these time frames in mind during your appointments. If you believe that your treatment issue merits a longer appointment than routine, please notify the staff at the time of the scheduling.

Many families prefer appointments after school for their children. These appointments are filled very quickly. Unfortunately, not all children can be seen outside of school hours. As a courtesy to the child and the family, we will gladly provide a doctor's excuse for appointments during school or work hours. Many families find that an early morning appointment is another very good alternative and minimizes school/work absence.

I understand the policies noted above. Dr. Balk and staff are authorized to submit my prescriptions electronically to my pharmacy and review them as necessary.

_____ _____

Signature of Patient or Guardian *Date*

_____ _____

Printed Name *Relationship to Patient*

Dr. Balk's E-mail Consent

1000 West 11th Street
Panama City, FL 32401
Telephone (850) 913-8313
Fax (850) 913-8314

Many patients prefer to utilize e-mail as a means to confirm or change appointments or to provide information to the office between appointments. Under Florida law, e-mail is not provided the degree of privacy that is permitted other forms of communication, such as telephone calls and letters. While all communication received by e-mail at this office will remain confidential and private, we recommend caution to our patients when using e-mail. I do not recommend my patients send very sensitive information by e-mail.

For those who wish to contact Dr. Balk and staff by e-mail, our address is balkoffice@knology.net. This e-mail is checked daily during the workweek by staff who also respond to all e-mail received at this address. Appropriate uses of this e-mail address might include:

- *Request a prescription refill*
- *Confirm or cancel an appointment*

Do NOT use this e-mail to communicate an emergency such as:

- *Suicidal or homicidal thoughts*
- *Severe medication reaction*
- *Other personal emergencies requiring an immediate response*

E-mail from patients will be printed and made a permanent part of the medical record. Dr. Balk will NOT personally respond. Be sure to include your first and last name and phone number in your email to avoid any confusion. Update our office regarding any changes in your e-mail address.

I consent to e-mail communication with Dr. Balk's office. I understand the risks and limitations of the use of e-mail. I understand that I can withdraw my e-mail consent at any time.

_____	_____
Patient or Guardian Name	*Date*
_____	_____
Patient or Guardian Signature	*E-Mail Address*

SIGNATURE OF RECEIPT OF PRIVACY PRACTICES

By signing, I acknowledge that I have received a copy of the Notice of Privacy Practices from the office of Susan Balk Kradel, MD.

Signature _____ Date _____

Patient _____ DOB _____

Effective Date:
This Notice is effective April 14, 2003.

NOTICE OF PRIVACY PRACTICES

Susan Balk Kradel MD

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY AND ACKNOWLEDGE RECEIPT.

This office is required by law to maintain the privacy of protected health information (PHI) and to provide our patients with our Notice of Privacy Practices. Dr. Susan Balk Kradel, MD and employees will share individual patient health information only as is necessary to provide quality health care and receive reimbursement for those services as permitted by law.

We reserve the right to change our privacy practices and the terms of this Notice at any time. A copy of any revised notices will be available in this office, or, upon request. The terms of this Notice of Privacy Practices are effective April 14, 2003.

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

Treatment, Payment, and Health Care Operations
This office will maintain the confidentiality of your individual health information. Your individual health information may be used and disclosed as customary and reasonable for purposes of treatment, payment, and health care operations. Outside of these permitted uses, we must have your signed authorization unless the law requires the use or disclosure without your authorization.

Business Associates
At times it may be necessary for us to provide your health information to certain outside persons or entities that assist us with our health care operations, such as auditing, accreditation, legal services, etc. Our business associates are required to properly safeguard the privacy of your health information.

Appointments and Services
We may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. You have the right to request to receive communications regarding your health information from us by alternative means or at alternative locations. You may request such confidential communication by sending your written request to Dr. Susan Balk Kradel, MD.

USE AND DISCLOSURES REQUIRING YOU TO HAVE AN OPPORTUNITY TO OBJECT

We will not disclose your private health information to friends or family, except guardians, without your express written authorization. We will not publish your name or identifying information in any directory.

USES AND DISCLOSURES OF PHI

The following uses and disclosure of PHI may be made without your prior consent or authorization.

Required By Law
If we suspect child abuse or neglect, we must release health information as required by law. If we receive a subpoena for your personal health records related to suspected criminal activity, we will attempt to work with you to determine the extent of release of information you desire.

To Avert Threat to Health and Safety
In the event of imminent serious risk of harm to self or others, such as acute suicidality or homocidality, we are obligated to report such threat and take action to prevent harm to self or others.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Restrictions on Use and Disclosure of Individual Health Information
You have the right to request restrictions on certain uses and disclosures of your protected health information. We cannot agree to limit uses/disclosures when required by law. You also have the right to terminate any agreed-to restriction by notifying our office.

Access to Individual Health Information
You have the right to request a copy or summary of your individual health information. Any such requests must be made in writing and signed by the patient or guardian. A fee may be assessed for the preparation of a summary of the requested information. We will respond within 30 days unless an extension is taken.

Amendments to Individual Health Information
You have the right to request that your health information be amended or corrected. We are not obligated to make any requested amendment, but will give any request careful consideration. All amendment requests must be in writing, signed by the patient or guardian, and must state the reasons for the amendment. If we make an amendment, we may notify others who have copies of the un-amended record if we believe that such notification is necessary.

Accounting for Disclosures of Individual Health Information
You have the right to receive an accounting of disclosures of your health information made by us after April 14, 2003. Requests must be made in writing and signed by the patient or guardian. We maintain the right to assess a charge for this service.

CONTACT INFORMATION

If you have questions about this Notice or any complaints about our Privacy Practices, please contact Mari Gildersleeve, Privacy Officer, 1000 West 11th Street, Panama City, FL 3240. Or call 850-913-8313. There will be no retaliation for filing a complaint.

You have the right to a copy of this or any revised Notice of Privacy Practices.

HOW TO FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe that your privacy rights have been violated, you can file a complaint to the office of Susan Balk Kradel, MD and/or to the Secretary of the US Department of Health and Human Services at 200 Independence Avenue, SW, Washington D. C. 20201 or call 1-877-696-6775.

Susan Balk Kradel MD and Associates PA
1000 W 11th Street
Panama City, FL 32401
Phone (850) 913-8313
Fax 850) 913-8314

Patient Name: _____ Patient DOB: _____

To Current and Prospective Patients or Guardians:

Your decision to seek mental health treatment for yourself or your family member was not made lightly. You likely gave the decision to do so much thought before you sought evaluation and treatment. Such consideration is appropriate.

Similarly, a physician's decision to treat a patient for mental health issues also requires much consideration. A physician accepts a great deal of responsibility when initiating or maintaining psychiatric treatment. This is especially true when treating children.

For these reasons it is imperative that the physician and patient or guardian recognize several key parameters in treatment with me:

1. Mental health treatment issues are private and ***confidential***. The physician cannot release any information except to a parent or guardian without the patient or guardian's written permission. This includes information to other family members, school officials, other doctors or other mental health providers (counselors).

2. Mental health professionals are required by law to report any concerns of abuse or neglect to the ***Florida Abuse Hotline***. This is an exception to the confidentiality noted above. Failure of the professional to do so can result in legal charges to the mental health provider.

3. Psychiatric treatment of a child requires the consent of ***both*** parents if both are guardians of the child. I encourage involvement by both parents in my evaluation and treatment of a child, particularly if one parent has reservations about treatment or has unique observations of the child. However, if one parent refuses to allow treatment or medication, I legally cannot provide that treatment.

4. Psychiatric medications, by nature, affect a patient's cognitions and thought processes. Many have serious potential medical side effects. It is imperative that patients on psychotropic (psychiatric) medications see their psychiatrist regularly for evaluation of these effects. If laboratory studies are ordered, these ***must*** be

BOTH SIDES

completed in a timely manner. Failure to keep appointments or comply with the doctor's requests for laboratory or other medical studies may result in termination of the medication or termination of treatment. ***I will not write a prescription for any patient I have not seen in over three months.***

5. ***If you are unable to keep a scheduled appointment please cancel at least 24 hours before the appointment.*** If you do not keep a scheduled appointment or you cancel at the last minute, you are interfering with another patient's potential ability to meet with me. A pattern of repeated no-shows or cancellations of appointments will result in termination of treatment. I will not refill a prescription for a patient who did not show up at the last scheduled appointment.

6. Many of the medications I prescribe are very tightly monitored and controlled by the US Drug Enforcement Agency (DEA). I, too, monitor the dates and numbers of pills prescribed for these medications. ***I will not write prescriptions for these medications before they are due.*** A pattern of lost prescriptions or early requests for refills may result in discontinuation of that medication or of treatment.

7. Medications must be taken exactly as prescribed. ***Medications that are prescribed by the doctor should only be taken by the person to whom they are prescribed.*** Sharing medication with others can result in legal charges against the person who shared them, and/or against the doctor who prescribed them. I take this very seriously and will not continue to treat those who violate this parameter. I will initiate legal charges if appropriate for diversion of controlled substance.

8. ***I will not prescribe a medication for someone I have not seen in evaluation. I will not provide prescriptions for chronic pain or other medical problems.*** I will be happy to refer such requests to another physician or schedule an evaluation for a new patient.

9. ***Payment is due at the time of service.*** Failure to maintain payment for services will result in termination of treatment.

I hope this information is useful in clarifying some of my policies in treatment. Do not hesitate to discuss any of these points with me for clarification, if necessary.

Susan Balk Kradel, MD

Signed: _____ Date: _____

Relationship to Patient: _____