# Embracing Life Wellness Center

Melissa Fickey, M.D.

SARAH CASH, A.R.N.P. • STEPHANIE FRANK, A.R.N.P. • TIFFANY JOSEPH, A.R.N.P.

## FINANCIAL POLICY

***WE DO NOT BILL FOR CO-PAYMENTS, DEDUCTIBLES, OR OUTSTANDING BALANCES***
****ALL FEES AND BALANCES WILL BE COLLECTED AT THE TIME OF CHECK IN****

**We accept Cash, Visa. MasterCard, and American Express**

****WE DO NOT ACCEPT CHECKS AS A FORM OF PATIENT PAYMENT****

If you present for an appointment with a check as your only form of payment, your appointment will have to be rescheduled to another date when you can bring in cash or credit card as a payment.

### INSURANCE

As a courtesy, if a patient is covered by a policy of insurance in which Dr. Melissa Fickey is a participating or contracted provider, a claim will be forwarded on the behalf of the patient to the insurance company for payment. Filing of said insurance claim may be forwarded to the insurance company by first class mail or electronically. We may accept assignment of insurance benefits at your initial visit. The balance is the patient's ultimate responsibility regardless of insurance payment or not. We require a copy of the insurance card and photo identification for our records before we agree to submit a claim on the patient's behalf to the insurance carrier. In the event that we do not have a provider agreement with a particular insurance carrier or we are considered an out of network provider for the patient's insurance plan, we will collect payment in full for any services at the time they are rendered. **We do not submit claims for payment to any insurance carrier that we are considered an out of network provider.** If we bill the insurance company and we do not receive payment from them within 90 days of the treatment date, the balance will be transferred to the patient and becomes the patient's financial responsibility. Please be aware that after a claim has been submitted to the insurance company, that particular insurance company can, in some cases, consider the services rendered not reasonable or necessary or may not be considered as a covered service under the medical insurance plan. For insurance plans that are considered "in network," **all copayments and deductibles will be collected at the time services are rendered.** In accordance with our agreement with the particular insurance carrier, the patient will only be charged for applicable co-pays or deductibles as dictated by the insurance plan. If, however, we receive a denial from the insurance company stating that benefits have terminated or the patient is no longer eligible for coverage, please refer to the paragraph above. Many insurance companies require that patients obtain a pre-authorization for mental health or substance abuse services**. It is the responsibility of the patient to obtain this pre-authorization and failure to do so will result in the patient being responsible for all costs incurred for their services.** If an insurance company has a restriction regarding the payment of these fees, the patient's signature hereby waives the rights the insurance company specifies. If the patient is a Medicare patient paying self-pay (we are not in network with Medicare) please be aware the self-pay rates are $300.00 for an initial evaluation (procedure code 90792) and $100.00 a visit for medication management (procedure code 99213). If the follow up appointment goes over 15 minutes, an additional charge will be applied.

### MINOR PATIENTS

A legal guardian or parent must accompany all patients under the age of 18 to their appointments. The legal guardian or parent that accompanies any child to an appointment must be prepared to make payment at the time services are rendered. We do not bill any party that is not present at the time of the appointment for services rendered, regardless of any court order or decree that deems another party (that is not present) is financially responsible for the child's expenses. It is the responsibility of the adult accompanying the minor to the appointment to recover or seek reimbursement for their expenses from the legally obligated party. Unaccompanied minors will not be seen unless prior arrangements have been made with our office.

### MISSED APPOINTMENTS

It is our office policy that appointments should be canceled with at least a 24-hour notice. Failure to show for or notify of an appointment cancelation will result in a No-Show fee being charged to your account. **Charges are $50.00 for a follow up appointment and $100 for a new patient appointment.** This fee is not billed to or covered by insurance.

### OTHER CHARGES

There will be a fee charged for the completion of any paper work or letters written on behalf of any patient including but not limited to FMLA, disability determination paperwork, medical narratives, treatment summaries, hospital homebound, treatment facility applications, intensive outpatient applications, and partial hospitalization application forms. **There will be a minimum fee of $25.00 up to a maximum fee of $250.00 charged for the completion of any items.**

### ACCOUNT BALANCES

We require that self-pay patients with balances due to pay the account balance to zero prior to receiving further treatment. **Patients with balances over $100 must make payment arrangements prior to scheduling future appointments.** Patients with questions about balances or would like to discuss a payment plan option, may call and speak with a staff member with whom they can review their account.

_____ _____

Patient Signature or Legally Authorized Representative Date

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## FDA ADVISORY

This information is being provided for informational purposes regarding the FDA advisory that has been issued relating to antidepressants. The FDA has asked that most drug companies that manufacture antidepressants include a package warning regarding the worsening of symptoms and suicidality while being treated with antidepressant therapy. We are providing this information to make you aware of the FDA waring and to **stress the importance of monitoring of the patient while taking antidepressants**. Monitoring of the patient by our office will be handled regularly scheduled follow up appointments. **It is imperative that you keep follow up appointments as requested by the physician**. If there is need to inform the physician of a dramatic worsening in symptoms or if there are concerns that arise prior to the scheduled appointment, you are asked to contact our office.

## CLINICAL WORSENING & SUICIDE RISK

Patients with major depressive disorder, both adult and pediatric, may experience worsening of their depression and/or emergence of suicidal ideation and behavior (suicidality), whether or not they are taking antidepressant medications, and this risk may persist until significant remission occurs. Although there has been a long-standing concern with antidepressant, having a role in inducing such behaviors has not been established. Nevertheless, patients being treated with antidepressants should be observed closely for clinical worsening and suicidality, especially at the beginning of a course of drug therapy, or at the time of dose changes, either increases or decreases. Consideration should be given to changing the therapeutic regimen, including possibly discontinuing the medication in patients whose depression is persistently worse or whose emergent suicidality is severe, abrupt in onset, or was not part of the patient's presenting symptoms.

Because of the possibility of co-morbidity between major depressive disorder and other psychiatric and non-psychiatric disorders, the same precautions observed when treating patients with major depressive disorder should be observed when treating patients with other psychiatric and non-psychiatric disorders.

The following symptoms, anxiety, agitation, panic attacks, insomnia, irritability, hostility (aggressiveness), impulsivity, akathisia (psychomotor restlessness), hypomania, and mania, have been reported in adult and pediatric patients being treated with antidepressants for major depressive disorder as well as for other indications, both psychiatric and non-psychiatric. Although a causal link between the emergence of such symptoms and either the worsening of depression and/or the emergence of suicidal impulses has not been established, consideration should be given to changing the therapeutic regimen, including the possibility of continuing the medication, in patients for whom such symptoms are severe, abrupt in onset, or were not part of the patients presenting problems.
Families and caregivers of patients being treated with antidepressants for major depressive disorder or other indications, both psychiatric and non-psychiatric, should be alerted about the need to monitor patients for the emergence of anxiety, agitation, irritability, and the other symptoms described above, as well as the emergence of suicidality, and to report such symptoms immediately to health care providers.

A major depressive episode may be the initial presentation of bipolar disorder. It is generally believed (though not established in controlled trials) that treating such an episode with an antidepressant alone may increase the likelihood of precipitation of a mixed/manic episode in patients at risk for bipolar. Whether any of the symptoms described above represent such a conversation is unknown.

Decision to start antidepressant therapy has been based on the **benefit vs risk ratio**. You as patient or guardian/parent of the patient have agreed to this course of therapy knowing the possible risks associated with these treatments.

Patient Signature or Legally Authorized Representative

Date

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Child, Adolescent, & Adult Psychiatry
Authorization for Verbal Communication and/or to Leave Voicemail Messages
(This does NOT authorize release of copies of medical records)

Patient Name: _____

Date of Birth: _____
Month/ Day/ Year

Patient Authorization: I hereby authorize Embracing Life Wellness Center to leave detailed, personal health information by the following means:

- o Voicemail message at my home number: _____
  (area code and number)
- o Voicemail message at my work number: _____
  (area code and number)
- o Voicemail message on my cellular phone: _____
  (area code and number)
- o Voicemail at a different location: _____
  (area code and number)
- o Verbal message with my spouse or partner: _____
  (name of spouse or partner)

  _____
  (area code and number)
- o Verbal message with other family member: _____
  (name of family member)

  _____
  (area code and number)
- o Other: _____

With my signature below, I acknowledge and understand that this authorization will be kept in my medical record and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Embracing Life Wellness Center in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

_____ _____

Patient Signature or Legally Authorized Representative Date

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# PATIENT CODE OF CONDUCT

Patient's Name:_____

As the patient or legal guardian, I agree to accept the terms of this patient code of conduct agreement.

**INITIAL EACH LINE**

_____ I agree to keep and be on time to all my scheduled appointments. I understand that frequent missed appointments or late cancellations (not calling 24 hours prior) may result in being dismissed from the office.

_____ I agree to notify the office of any changes to personal information such as name, address, telephone, or insurance changes.

_____ Due to limited space in the waiting room, I agree to only bring myself and possibly a supportive advocate to my appointments, arranging for childcare before my appointment day and time. Additionally, If I am an adult accompanying a minor, I will bring only the child for whom the appointment is for.

_____ If I am an adult accompanying a minor, I agree to supervise the child while in the office to avoid unruly behavior.

_____ I agree to adhere to the payment policy outlined by this office and keep my account in good standing.

_____ I understand that an additional therapy code may be added for an extra charge should a visit exceed 15-20 minutes.

_____ I agree to conduct myself in a courteous manner towards the staff and providers.

_____ I understand that if I am disrespectful to staff or disrupt the care of other patients, my care may be terminated.

_____ I agree to respect the rights and property of the staff and other persons in the office.

_____ I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in termination without any recourse for appeal.

_____ I agree not to deal, steal, or conduct any illegal or disruptive activities in the provider's office.

_____ I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I understand that lost or stolen medication will not be replaced regardless of the reason for loss.

_____ I agree not to obtain any controlled medications from any doctors, pharmacies, or other sources without telling my provider.

_____ I agree to take my medication as my provider has instructed and not to alter the way I take my medication without first consulting my provider.

_____ I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my provider and specified in my treatment plan.

_____ **I understand that violations of the above may be grounds for termination of treatment.**

_____ _____

Patient Signature or Legally Authorized Representative Date

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6332 US HWY 301 S
RIVERVIEW, FL 33578

PH: (813) 662-5919
FX: (813) 671-8374


## AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____ Patient Name:_____ DOB:_____/_____/_____

This authorization will allow Dr. Fickey to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

PRIMARY CARE PROVIDER:

(Name of Agency/ Organization/ Professional or Individual)

Address Information

Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Melissa Fickey, M.D. cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

**PLEASE CHECK ALL THAT APPLY BELOW**

| | | |
|---|---|---|
| ___Physician Discharge Summary | ___Psychological Evaluation | ___Medical History |
| ___History/ Physical Examination | ___Psychiatric Evaluation | ___Lab Results |
| ___Consultation | ___Progress Notes | ___Diagnosis |
| ___Recommendation for Treatment & Care | ___Treatment Plans | ___Verbal Communications |
| ___Psychiatric Discharge Summary | ___Billing Records | ___Insurance Coverage Info |
| | **_____ENTIRE FILE** | |

Other Information:_____

**The purpose for the release and disclosure of this protected health information is for:**

___Continuation of Care ___Coordination of Care/Treatment Other: _____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as void as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Melissa Fickey, M.D. is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

### Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization is made by the patient or patient's guardian and provided to Embracing Life Wellness Center. This authorization shall remain valid for the duration for which the patient is receiving care and treatment at Embracing Life Wellness Center. Voluntary cessation of treatment or if the patient is discharged from the practice involuntarily will terminate the validity of this release.

_____ _____
Patient Signature (If patient is over the age of 18) Date

_____ _____
Legally Authorized Representative's Signature Date

_____ _____
Witness Signature Date

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## AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____ Patient Name:_____ DOB:_____/_____/_____

This authorization will allow Dr. Fickey to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

INSURANCE COMPANY NAME ONLY:

(Name of Agency/ Organization/ Professional or Individual)

Located on the Back of the Card

Address Information

Located on the Back of the Card

Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Melissa Fickey, M.D. cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

**PLEASE CHECK ALL THAT APPLY BELOW**

| | | |
|---|---|---|
| ___Physician Discharge Summary | ___Psychological Evaluation | ___Medical History |
| ___History/ Physical Examination | ___Psychiatric Evaluation | ___Lab Results |
| ___Consultation | ___Progress Notes | ___Diagnosis |
| ___Recommendation for Treatment & Care | ___Treatment Plans | ___Verbal Communications |
| ___Psychiatric Discharge Summary | _X_Billing Records | _X_Insurance Coverage Info |
| | **_____ENTIRE FILE** | |

Other Information:_____

**The purpose for the release and disclosure of this protected health information is for:**

___Continuation of Care ___Coordination of Care/Treatment Other: _____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as void as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Melissa Fickey, M.D. is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

### Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program which is to make the disclosure has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization is made by the patient or patient's guardian and provided to Embracing Life Wellness Center. This authorization shall remain valid for the duration for which the patient is receiving care and treatment at Embracing Life Wellness Center. Voluntary cessation of treatment or if the patient is discharged from the practice involuntarily will terminate the validity of this release.

_____ _____

Patient Signature (If patient is over the age of 18) Date

_____ _____

Legally Authorized Representative's Signature Date

_____ _____

Witness Signature Date

# Embracing Life Wellness Center

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Patient Name:_____ Date:_____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. In rare, unforeseen circumstances, there may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The aforementioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I understand that billing will occur from my practitioner.
6. I have had a conversation with my office, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

_____ _____

Patient Signature/Parent or Guardian Date

_____ _____

Witness Signature Date