

BILLING RATES AND POLICIES

CURRENT FEE SCHEDULE:

- New patient evaluation (75 min) \$500
- Medication Check (15-20 min) \$150
- Follow up visit (25-30 min) \$225
- Extended Follow up Visit (35-45 min) \$300
- Psychotherapy / Extended Follow up Visit (50-60 min) \$450

Note: Dr. Leicken does not perform disability evaluations or provide evaluations to be used in litigation or other legal matters

BILLING & ATTENDANCE POLICIES:

• **ALL PAYMENTS ARE DUE AT TIME OF SERVICE.** While we do not contract with or submit to insurance, we may provide you with a one page "Superbill" with all the necessary information for you to submit to your insurance company for reimbursement.

• Phone consultations/document preparation taking longer than 5 minutes will be charged in 10 minute increments at \$75.00 per increment. Multiple calls will be aggregated per 24 hour period.

• **PATIENTS/ GUARANTORS MUST MAINTAIN A CURRENT CREDIT OR DEBIT CARD ON FILE.**

This information will only be used for actual charges incurred, including phone consults, requested reports, and missed or late-canceled appointments. You are always welcome to use an alternate form of payment so long as it is offered at time of service.

• There is a 24 hour cancellation policy. **YOU WILL BE BILLED FOR THE FULL AMOUNT FOR ALL MISSED OR LATE-CANCELLED APPOINTMENTS. It is your responsibility to keep track of and come to your appointments.**

• A \$50 fee will be charged for all returned checks. The patient agrees to reimburse this office for any Collection and /or legal charges incurred as a result of patient's failure to honor his/her bill.

BILLING INFORMATION:

Party responsible for payment _____ Phone _____

Responsible party address _____
Street City State Zip Code

VISA/MC _____ Exp.Date: _____

INSURANCE INFORMATION :

(Note: We gather insurance information solely for the purpose of expediting coverage for your prescriptions. Some insurance carriers require prior authorization to cover medications and will require us to submit forms on your behalf for approval. **We do not contract with insurance for any services.**)

Carrier Name _____ Member ID _____

Group ID _____ Customer Service # _____

I have read, understand, and agree to abide by the foregoing billing & attendance policies. I understand that the foregoing agreement is binding in the state of Arizona. I hereby give express permission to David Leicken, MD (or the staff of Ironwood Behavioral Health, LLC at his direction) to charge my card on file for charges incurred where I have not previously or simultaneously arranged alternate payment.

Responsible Party Signature Date

Witness Date

PHYSICIAN-PATIENT AGREEMENT

This agreement serves to inform Dr. Leicken's patients regarding office policies, physician policies, and the Physician-patient relationship. Please read this agreement in its entirety and sign where indicated to acknowledge your understanding of this agreement and to abide by the policies contained therein.

ATTENDANCE POLICY: Dr. Leicken requires that all patients taking CII medication (generally, stimulants) be seen every three months and that those taking CIV medications (generally, benzodiazepines) to be seen every 4 months. All others on medication should generally be seen at an interval not greater than 6 months. Failure to maintain a regular attendance schedule may affect your ability to receive refills in a timely manner.

PRESCRIPTION POLICY: Prescriptions may be requested by email (info@ironwoodbh.com ***Please note that email is not considered confidential***) or by phone (602-910-4050). Please allow up to 48 hours for processing new prescriptions. Alternatively, you may contact your pharmacy directly; and they will initiate the proper procedure. ****Please make sure to allow sufficient time for processing on all prescriptions, especially on weekends, so that you do not run out of your medication.**

CONFIDENTIALITY POLICY: Please see attached "Arizona Notice Form."

RE: THE MEDICAL INFORMATION BUREAU: Health insurance policies sometimes require patients to release all encounter information for any service rendered that is claimed against the health care plan. The diagnosis and treatment information required on the claim form is often then forwarded to the Medical Information Bureau (MIB), where it becomes available to other insurance companies without the patient's knowledge or consent. For this reason, Dr. Leicken cautions all patients that the release of any information through the claims filing process *may* present a potential risk that could be personally damaging to unknowing patients should an inappropriate party gain access to the MIB national database.

PATIENT/PHYSICIAN RESPONSIBILITIES: Each patient is responsible for providing accurate contact and billing information. If a patient's telephone, email, or address changes it is the duty of that patient to inform Dr. Leicken's office immediately to avoid disruption of communication.

Examination and treatment provided by Dr. Leicken is limited to outpatient psychiatric services. The patient should be aware that this does not necessarily constitute total or definitive psychiatric care, and that further evaluation and treatment may be required in some cases. It is the patient's responsibility to obtain follow up medical care for general health as needed or when advised to do so by Dr. Leicken. The patient further acknowledges that psychiatry is a specialty within the field of medicine and is not meant to be a substitution for primary medical care.

TERMINATION POLICY: Dr. Leicken reserves the right to terminate any patient who violates treatment protocol, is generally non-compliant (with respect to treatment directives or office policies), willfully disregards treatment objectives that are designed to obtain positive clinical outcomes, or is rude or disrespectful to him or his staff. He will continue to treat the terminated patient on an *emergency basis only* for 30 days after termination.

STORAGE, TRANSFER & ACCESS TO PATIENT RECORDS ON TERMINATION OF THE PRACTICE:

In the event of the termination of Dr. Leicken's practice, the doctor (or a designee from his staff) will post two notices in the Arizona Republic, two weeks apart, regarding the close of the practice and information for locating medical records. The doctor or his staff designee will further advise all active clients (by letter or direct verbal communication) where and how they may contact the doctor for purposes of interim/transfer care or to request their records. Patients will be provided either a phone number to contact the doctor directly or with numbers for the Arizona Psychiatric Association or the Arizona State Medical Board, who will be able to properly direct requests (the doctor will maintain current contact with both associations during

the required period for records retention). The doctor will maintain a professional telephone contact number for a period of three to six months, depending on circumstances surrounding the closure of the practice. To protect personal privacy, the doctor or his staff designee will only provide direct access numbers to active or recent (6 months inactive) patients. *Inactive* patients will be able to direct records requests to the Arizona Psychiatric Association or the Arizona State Medical Board. The doctor will maintain records electronically, and they will be stored off site with a secure, encrypted storage service. Medical records are obtainable through:

Ironwood Behavioral Health, LLC
8124 E Cactus Road, Suite 410
Scottsdale, Arizona 85260
602-910-4050

The doctor or his staff designee will respond in a timely manner to patient requests for copies or access to their medical records. Unless prohibited by illness, temporary travel unavailability, or death, the doctor will respond within 30 days or other legally or ethically mandated time frame. The doctor or his staff designee will dispose of unclaimed records after the legally specified time for retention by destroying said records such no confidential information remains in useable form.

In the event that circumstances require, the doctor or his staff designee will forward access and responsibility to another professional who will respond to records requests in accordance with legal and professional standards as set forth by the Arizona Psychiatric Association and the Arizona State Medical Board.

I have read, understand, and accept the provisions of this Physician-Patient Agreement, and have no questions about the policies outlined herein. I understand that if I violate any provisions of this agreement my treatment may be terminated. I understand that this agreement is binding in the state of Arizona and that the provisions herein are for my protection and the protection of Dr. Leicken. The original, signed agreement will become part of my private medical record and I am entitled to a copy at my request.

Patient signature

Date

Witness signature

Date

CONSENT FOR TELEPSYCHIATRY SERVICES

Introduction

Telepsychiatry Services means the remote delivering of psychiatric services via technology assisted media. This includes a wide array of clinical services and various forms of technology. The technology includes but is not limited to video, internet, a smartphone, tablet, PC desktop system or other electronic means. The delivery method must be secured by two-way encryption to be considered secure. Synchronous (at the same time) secure video chatting is the preferred method of service delivery.

Limitations of Tele Mental Health Therapy Services:

While Telepsychiatry Services offers several advantages such as convenience and flexibility, it is an alternative form of treatment delivery and may involve disadvantages and limitations. For example, there may be a disruption to the service (e.g. phone gets cut off or video drops). This can be frustrating and interrupt the normal flow of personal interaction. Primarily, there is a risk of misunderstanding one another when communication lacks visual or auditory cues. For example, if video quality is lacking for some reason, it may be difficult to see various details such as facial expressions. Or if audio quality is lacking, it may be difficult to hear differences in your tone of voice that could be more easily picked up in an office setting. Additionally, treatment in an office setting decreases the likelihood of interruptions that may be encountered in an alternative setting such as being at home. Please note that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no personally identifiable information obtained in the use of telepsychiatry will be disclosed to other entities without a written release of information. There will be no recording of audio or video during telepsychiatry sessions.

Patient Responsibilities for Telepsychiatry Services:

Telepsychiatry sessions can only be conducted while the patient is within the state of Arizona. Telepsychiatry sessions must be conducted with a reliable connection to minimize disruption. This may include Wifi, Ethernet or a strong cellular connection. It is strongly suggested that you only communicate through a device that you know is safe and technologically secure (e.g. has a firewall, anti-virus software installed, is password protected, not accessing the internet through a public wireless network, etc.) Do not use "auto-remember" for names and passwords. Make sure you have checked your company's policy before using a work computer for personal communication. As the patient, you are responsible for finding a private, quiet location where the sessions may be conducted.

In Case of Technology Failure:

I understand that during a Telepsychiatry session, technological failures can occasionally be encountered. These may include difficulties with hardware, software, equipment, and/or services supplied by a 3rd party that may result in service interruptions. In the event of a disruption, the session may be continued by telephone. If neither video conferencing nor telephone is available, the session may need to be rescheduled to a later time once the disruption has been resolved.

I have read, understand, and accept the provisions above and consent to receiving Telepsychiatry Services

Patient signature

Date

Witness signature

Date



David Leicken, MD
Board Certified Psychiatrist

8124 E Cactus Road, Suite 410
Scottsdale, Arizona 85260
602-910-4050

IronwoodBehavioralHealth.com

ARIZONA NOTICE FORM

Notice of Psychiatrist's Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHIATRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

I may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

- "PHI" refers to information in your health record that could identify you.
- "Treatment" is when I provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider, such as your family physician or another psychiatrist.
- "Payment" is when I obtain reimbursement for your healthcare. Examples of payment are when I disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
- "Health Care Operations" are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "Use" applies only to activities within my office such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "Disclosure" applies to activities outside of my office, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

I may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when I am asked for information for purposes outside of treatment, payment or health care operations; I will obtain an authorization from you before releasing this information. I will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes I have made about our conversation during a private, group, joint, or family counseling session, which I have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI. You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) I have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

I may use or disclose PHI without your consent or authorization in the following circumstances:

- Child Abuse – I am required to report PHI to the appropriate authorities when I have reasonable grounds to believe that a minor is or has been the victim of neglect or physical and/or sexual abuse.
- Incapacitated Adult Domestic Abuse – If I have the responsibility for the care of an incapacitated or vulnerable adult, I am required to disclose PHI when I have a reasonable basis to believe that abuse or neglect of the adult has occurred or that exploitation of the adult's property has occurred.
- Health Oversight Activities – If the Arizona Board of Psychiatric Examiners is conducting an investigation, then I am required to disclose PHI upon receipt of a subpoena from the Board.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under state law, and I will not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- Serious Threat to Health or Safety – If you communicate to me an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim(s) and I believe you have the intent and ability to carry out such a threat, I have a duty to take reasonable precautions to prevent the harm from occurring, including disclosing information to the potential victim and the police and in order to initiate hospitalization procedures. If I believe there is an imminent risk that you will inflict serious harm on yourself, I may disclose information in order to protect you.
- Worker's Compensation – I may disclose PHI as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights

- Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.
- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, I will send your bills to another address.)
- Right to Inspect and Copy – You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, I will discuss with you the details of the request and denial process.
- Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss the details of the amendment process.
- Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. On your request, I will discuss with you the details of the accounting process.
- Right to a Paper Copy – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically. The fee is determined pursuant to Arizona Revised Statutes §12-351-(F)(1).

V. Psychiatrist's Duties

I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI. I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect.

VI. Questions and Complaints

If you have questions about this notice, disagree with a decision I make about access to your records, or have other concerns about your privacy rights, you may contact my office manager, at 602-910-4050. If you believe that your privacy right has been violated and wish to file a complaint with me/my office, you may send your written complaint to me or my office manager at:

Ironwood Behavioral Health, LLC
8124 E Cactus Road, Suite 410
Scottsdale, Arizona 85260

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. My staff can provide you with the appropriate address upon request. You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VII. Effective Date and Changes to Privacy Policy

This notice will go into effect on October 1, 2022 Any revisions will be made in writing and will be available in my office at 8124 E Cactus Road, Suite 410, Scottsdale, Arizona 85260 and on my website at www.IronwoodBehavioralHealth.com in the intake packet section. Current patients will receive an updated copy of my policies and procedures in person in my office or via US mail. In either case, those patients will be required to fill out and sign an acknowledgment of receipt of updated policies; failure to do so will result in termination of care.

