Marilou C. Rosas Behavioral Health, Inc.

"Bringing Quality to Psychiatry Medicine"

32605 Temecula Pkwy, Suite 219, Temecula, CA 92592

Tel: 951.506.9112 www.mcrbehavioralhealth.com Fax: 951.346.9113

OFFICE BILLING & INSURANCE POLICIES/AUTHORIZATION:

1. I authorize payment to be made directly to this provider.
2. I authorize the release of any information necessary to process claims.
3. I understand that I am responsible for payment of services I receive whether or not my insurance covers these services.
4. Services may include, but are not limited to: report/letter writing, no show appt, phone consultations, etc.
5. I understand that it is my responsibility to pay any deductible amount, copay, or coinsurance amount not paid by my insurance and it is due at the time of each visit.
6. I understand there is a 24-hr cancellation policy, which requires that I cancel my appt 24 hrs in advance between 9 am and 4:30 pm, Mon-Fri or I will be charged for this appt.
7. I understand that this office is not a Medical provider. I will be totally responsible of all payments, if I have Medical insurance.
8. I understand this office has an ongoing "Patient Policy" and agree to abide by.
9. I understand that if my account is 90 day past due or exceeds $100.00 without prior payment arrangements, I will be subject to appt cancellation and no medication refills will be authorized.
10. I understand that in the event of a court case, MCR Behavioral Health, will NOT testify in court on my behalf. And, if court mandated, I understand I will be responsible for a fee of $500.00 and up for chart review of my case.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____

NOTIFICATION OF PRIVATE PRACTICES:

Although your medical record is the physical property of our facility, the information belongs to you. You have the right to:
Obtain a paper copy of the notice of privacy upon request.
Obtain copies of your health records.
There will be a processing fee for all records request or copied according to the extent of the request. Records will be processed within 2 weeks from the date of the request.
We reserve the right to change our policies and to make new provisions effective as deemed necessary.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____

CLINICAL POLICY:

If any clinical within MCR Behavioral Health, suggests inpatient hospitalization for patient safety and:
Patient refuses hospitalization, or
Clinician is forced to call authorities for patient safety, or
Patient leaves hospitalization against medical advice (AMA)
If any clinician of MCR Behavioral Health, requests Urine Drug Screen, planned or random, and:
Patient refuses to complete U.D.S. on day requested, or
U.D.S. is returned with positive results without patient disclosure of usageIn the event a prescription is lost or stolen, there will be absolutely NO early refills on medications, including, but not limited to controlled substances such as:

Benzodiazepines and stimulants(i.e. Clonazepam, Xanax, Ativan, Adderall, Concerta, etc.)

By signing below, I acknowledge all of the above and understand that this behavior is grounds for immediate discharge from MCR Behavioral Health.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____

INITIAL EVALUATION DISCLAIMER:

By singing below, I understand the initial evaluation with MCR Behavioral Health, is an evaluation only and will be used to determine if a working treatment plan can be achieved. I also understand that all fees for all services are non-reimbursable and at the conclusion of the initial evaluation. I understand that further treatment may or may not be possible based on the result of the evaluation.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____

FOLLOW UP PROCEDURE:

Review of Records: 5-10 minutes

Before the patient is seen, the patient's records or the latest follow-up notes are reviewed for the clinician to be well aware of the patient's latest situation and condition. Amongst the items that need to be reviewed and are not limited to: treatment plan, histories, current medication and other issues that may have occurred in between follow-up schedules.
Session: 20-60 min sessions

This is a face to face meeting with the patient. Most of the time is spent for psychotherapy. Questions and answers, education, understanding patient's needs and concerns. This is critical for the patient care and treatment plan.
Documentation: 5-10 minutes

After the patient is seen, a documentation work is performed to record the important items discussed, discovered and agreed upon during the session. This is vital preparation for review for the next follow up session.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____

Informed for Consent TelePsychiatry Services:

I understand that TelePsychiatry is the use of electronic information and communication technologies used by Dr. Marilou Rosas to deliver services to me when Dr. Marilou Rosas is not in the office; and hereby consent to Dr. Marilou Rosas providing health care services to me via TelePsychiatry.
I understand the laws that protect privacy and the confidentiality of medical information also apply to TelePsychiatry. The system used is ClockTree; a HIPAA compliant secured portal. As always, your insurance carrier will have access to your medical records for quality review/audit.

Patient Name: _____Signature of Patient or Guardian:_____Date:_____