Marilou C. Rosas, MD
Janet Giangregorio, NP
Karen Larcher-Rowland, NP

Marilou C. Rosas Behavioral Health, Inc.

"Bringing Quality to Psychiatry Medicine"

32605 Temecula Parkway, #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 company covers these services. Services may include, but are not limited to: report/letter writing, court or attorney time, no- show appointments, telephone consultations, etc.
4. I understand that it is my responsibility to pay any deductible amount, co-pay, or co-insurance amount not paid by my insurance and is due at the time of each visit.
5. I understand there is a 24-hour cancellation policy, which requires that I cancel my appointment 24 hours in advance between 9:00 am and 4:30 pm, Monday through Friday, or I will be charged for the appointment.
6. I understand that MCR Behavioral Health, Inc. is NOT a MediCal provider. I will be totally responsible of all payments, if I have a MediCal insurance.
7. I understand the initial evaluation with MCR Behavioral Health Services, Inc. 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 results of the evaluation.
8. I understand MCR Behavioral Health, Inc. has an ongoing "Patient Policy" and agree to abide by.
9. Accounts that are 90 days past due or exceeding $100 without prior payment arrangements will be subject to appointment cancellation and no medication refills will be authorized.

Patient Name:_____ **Sign:** _____ **Date:**_____

NOTIFICATION OF PRIVACY 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 policies upon request.
- Inspect and copy your health record.
- Obtain an accounting of disclosures of your health information.

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:_____ **Sign:** _____ **Date:**_____

CLINICAL POLICY

If any Clinician within MCR Behavioral Health, Inc. 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)
- I understand in the event of going through a court case, MCR Behavioral Health, Inc. will not go and testify on my behalf.

If any Clinician within MCR Behavioral Health, Inc. requests a Urine Drug Screen (UDS), planned or random, and:

- Patient refuses to complete UDS on day requested, or
- UDS is returned with positive results without patient disclosure of usage
- In 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 (i.e. Clonazepam, Xanax, Ativan, etc.) and Stimulants (i.e. Adderall XR, Concerta, etc).

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

Patient Name:_____ **Sign:** _____ **Date:**_____

INITIAL EVALUATION DISCLAIMER

By signing below, I understand the initial evaluation with MCR Behavioral Health Services, Inc. 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 results of the evaluation.

Patient Name:_____ **Sign:** _____ **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 needs to be reviewed and are not limited to: treatment plan, histories, current medication and other issues that
may have occurred in between the follow up schedules.
Session: 20 minutes

This is a Face-to-Face meeting with the patient. Most of this time is spent for psychotherapy. Questions and answers, education, understanding the
patient's needs and concerns. This is critical for 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 face-toface
meeting session. This is vital in preparation for review for the next follow up session.

Patient Name:_____ **Sign:** _____ **Date:**_____

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Informed Consent for 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 in not in the office; and hereby consent to Dr. Marilou C. Rosas providing health care services to me via TelePsychiatry.

I understand that 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: _____

Date: _____

*Signature of Patient: _____

**(If patient is a minor, parent or legal guardian sign)*