Sorin Bircea, M.D.
PSYCHIATRIST

43-01 22nd Street, Suite 520, LIC, NY 11101

ACKNOWLEDGEMENT OF OFFICE POLICIES

Welcome to our practice. This document contains important information about my professional services and business policies. It also contains information about the Health Insurance Portability and Accountability Act (HIPAA), a Federal law that provides privacy protections and patient rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. You may revoke this Agreement in writing at any time. Please bring up any questions you have at your first appointment. All treatment here is voluntary. Please arrive on time for your appointment.

Office Hours: The office is usually open 5 days a week, by appointment. We may close the office for holidays or vacations.

Psychiatric Services: We offer the following psychiatric services: initial diagnostic interview, medication management, therapy/ counseling. You may be referred for testing/ therapy sessions to psychologists/ therapists, other medical professionals, or for lab/ imaging techniques.
Late Policy: Patients arriving more than 10 minutes late may have to wait until a slot will be open.

Emergency/After-hours Service: If you are in need of **emergency** services and cannot wait until next business day: call 1-888-NYC-Well, text WELL to 65173, or chat with a counselor at nyc.gov/nycwell or call National Prevention Lifeline 1-800-273-8255; eventually call 911 or proceed to the nearest hospital emergency room. In Overdose: call Poison Control Center 1-800-222-1222 for instructions. **After hours** and/or when the office is closed, you may leave a message on the voicemail for routine, non-urgent matters and your call will be returned during normal business hours.

Communicating with you: You agree and acknowledge that email, calls, texts or any form of messaging to your home, mobile, work or other contact will pertain to information regarding your appointments, test/ lab results, other after-hours issues. We can send you a courtesy reminder message the day before your appointment. In case you do not confirm, you may lose your scheduled visit. In case you miss an appointment and do not attempt to contact us within 4 weeks, your case will be closed. You can re-open the case for the same or different matter at any time, in which case we will charge this as initial visit. If you wish to extend communication regarding your specific medical treatment and share of information with others, we ask that you sign a Release of Information form.

Professional Records: The laws and standards of psychiatry require that we keep protected health information (PHI) about you in medical record. Except in unusual circumstances that involve danger to yourself and/or others, you may examine and/or receive a copy of your clinical record if you request it in writing. Because these are professional records, they can be confusing if read without the guidance of a mental health professional. For this reason, we should review them together in the office, or have them forwarded to another mental health professional to discuss the contents. If we refuse your request for access to your records, you have a right of review. Insurance companies can request and receive a copy of your clinical record. For details, see "Notice of Privacy Practices".

Confidentiality and Releasing of Protected Health Information: Your privacy is important to us. All protected health information (PHI) will be kept confidential. In most cases we will obtain your consent prior to releasing any PHI; however, records and/or PHI may be released regardless of consent in the following circumstances:
• According to state and local laws, I must report to the appropriate agencies all cases of physical and sexual abuse or neglect of minors (children under the age of 18), the disabled, and the elderly.
• According to state and local laws, I must report to the appropriate agencies all cases in which there exists a danger to self and/or others. Danger to Self – We may contact family/friends or call 911 if patients are threatening to harm themselves. Danger to Others – Patients threatening to seriously harm another person may compel us to contact the potential victim and/or police as we have a responsibility to protect the potential victim.
• When authorized by the recipient of services, in order to process medical insurance claims and authorized payment of benefits.
• In the event that a patient is in need of emergency services and other medical personnel need to be contacted.
• If you become involved in specific kinds of legal proceedings, the courts may subpoena information concerning your treatment.
• Consent to Release PHI – You or your legal guardian will be asked to sign a form granting us permission to release your PHI. This form will need to be signed before records can be released to your attorney, insurance company, other doctors/therapists, school, etc. Connecting with other medical professionals is usually recommended. Family or others may be involved pending your approval.
***Important Note**: Once your medical records leave our premises, we cannot be held responsible for their mishandling.

Patient Rights: HIPAA provides you with rights with regard to your clinical record and disclosures of PHI. These rights include requesting that I amend your record; requesting restrictions on what information from your clinical record is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records, and the right to request a paper copy of this Agreement.

Notice of Privacy Practices including Patient Rights and Responsibilities: a copy is available and posted in the office for your review or you may obtain a copy upon direct request.

_____ Please initial here, confirming that you have read, you understand and agree with each section of this page.

Non-Voluntary Discharge from Treatment: A client may be terminated from the office non-voluntarily, if: A) the patient exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter/e-mail. The client may appeal this decision or request to re-apply for services at a later date.

Treatment of Minors: We are not treating minors (i.e., below age 18) at any Office location. Should you bring minors with you to your visit, please understand that it is your sole responsibility to assure their safety. We cannot be held responsible for any injuries to minor(s) whom patients or visitors decide to bring into the Office.

Visitors, Personal belongings: Please assure the safety of people escorting you (family members, friends, others) and belongings. We cannot be held responsible for any injuries to other persons you bring into the Office and neither for loses/ damages which you as a patient may incur during your visit. We may ask for identification of people coming in with you and we held the right to accept or refuse their presence to our Office.

Medication Refill: It is your responsibility to contact the office before you run out of medications. Please make an appointment by contacting the Office at least 5 business days before your meds will run out.
Controlled substances (Stimulants, Suboxone, Benzodiazepines like Xanax, Klonopin, Ativan, Valium etc.) policy: by NY State Law I cannot give you more than 30 days' supply at a time, for which you have to be seen in person.
Non-controlled substances policy: we will offer you 5 days' refill if you missed the last appointment and contact the office yourself within 24 hours. A second consecutive emergency refill will NOT be granted for any medication.
I require that patients on psychiatric medication be seen at least once every 90 days. If a patient has not been seen in the office in the last 90 days, I will not issue a refill without a scheduled follow-up appointment. A patient in stabilized condition may be referred to the PCP for continuation of care if refills of more than 90 days are requested. Requests for refill made by pharmacies will not be granted without the patient contacting our office.

Payment and Billing: Payment (i.e. cash pay, copays, payment towards deductible) is due prior to your appointment on the day services are rendered. We bill your insurance as a courtesy. For non-insured services we charge $300 for initial visit and $120 for follow-up. You are ultimately responsible for payment of services you receive from our Office.
If your plan requires a referral, it is your responsibility to obtain it before your visit. In the event the balance on your account becomes 60 days delinquent after insurance payments, your account may be sent to our collection agency. You will be responsible for the collection fees incurred. Please be prepared to show us your insurance card at every visit so we can be prepared for possible changes in your coverage. Any changes in insurance coverage, your address, or demographic data has to be reported before the next visit.

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Patient's Name (Please Print) _____Date: _____

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Signature of Responsible Party **Printed Name**

RESOURCES:
FirstGov for Consumers: http://www.consumer.gov
United States Department of Health and Human Services: http://www.hhs.gov

***NOTE: Office policies mentioned above may suffer revisions. Please contact the office directly for the current update.**

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TREATMENT CONSENT

As a patient, I understand:
That I have been fully informed about the nature of the treatment, the risks and benefits, and the available treatment options.
That it is my full responsibility for taking the medication as prescribed.
That in case of overdose I should call local poison control center at 1-800-222-1222.
That I should not change the dosage of medication, the time that it is taken, or discontinue it without informing The Office.
That it is my full responsibility to safely store and secure the medication out of children in the family.
That having adults with me into the session may be beneficial at times. However, minors' presence represents a distraction. It may impair the depth of communication, and my evaluation and treatment choices may suffer in consequence.
That should I bring in children to The Office, the front desk staff cannot be held responsible for their care.
That I should watch for side effects and inform The Office if there is a problem with the medication.
That I should inform The Office if other medications are prescribed by other physicians or if over-the-counter medications are used to make sure there are no drug interactions between the medications been taken.
That e-mail should not be used for a crisis or emergency situation as I may not receive an immediate response. Security of email cannot be guaranteed, and I may wish to avoid the transmission of confidential information in email. If I choose to e-mail The Office, I am accepting this risk.
That text messaging should be used for scheduling issues only. If I need to discuss anything else between visits, I may call and leave a voicemail.
That it is my responsibility to obtain all necessary baseline and monitoring lab work/tests as ordered or suggested.
That it is my job to make sure there is an adequate supply of medication and that I do not run out before the next Office visit.
That I have had the opportunity to have all questions answered to my satisfaction.
That my condition may improve or not with or without the medicine.
That this consent is given voluntarily.
That I am legally competent and have the authority to provide consent for treatment.
That I have the right to withdraw my consent for this treatment at any time.
That withdrawing consent for this treatment will not prejudice my continued treatment relationship.
(Females of childbearing age only) I certify that I am not currently pregnant and will use appropriate contraceptive measures during the course of treatment with medications from The Office.
(Females only) If I plan to become pregnant or believe that I have become pregnant while taking this medication I will immediately inform my obstetric doctor and/or primary care provider and The Office. I am aware that should I carry a baby to delivery while taking these medications the baby may be injured during pregnancy and present with birth defects or developmental difficulties.
That I give consent for providing services via audio/ video teleconferencing when the situation implies (e.g., public health emergency).
Confidentiality issues were presented to me.

I understand that the information does not cover everything, but it includes items of clinical significance to me. I should discuss all my medical/ psychiatric problems and any medication that I take with my physician. For more information, I may refer to a pharmacist or to a standard text such as the Physician's Desk Reference (PDR). Other sources: National Institute of Health - https://www.nlm.nih.gov/medlineplus/druginformation.html
I have received the information about the psychotropic medication by means of oral explanation, printed material, and online presentation.

I understand and give consent to the medication(s) prescribed, which is/ are FDA approved medication(s), although its use in my condition(s) may not always appear as part of its approved labeling.
I understand that this "Informed Consent Form" is not intended to be "all inclusive" of aspects of my mental health treatment. It is only intended to provide some useful information before deciding to engage in mental health treatment.

FINANCIAL CONSENT

I authorize all relevant commercial payers to pay Sorin Bircea Physician P.C. on my behalf for any services furnished to me or my dependent. I also authorize Sorin Bircea Physician P.C. or my insurance company to release any information required to process my claims. I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection, I will be responsible for paying attorney fees, interest, court costs, and other costs of collection, including but not limited to collection agency fees. I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.

Client /Guardian signature _____**Date** _____

Physician signature _____**Date** _____