Hope, Healing & Holistic Psychiatry

Nicole L. Flanagan, PMHNP-BC, MSN, RN, BA

PATIENT TERMS

I, _____, have read the information provided below and have discussed any concerns with my provider, **Nicole L. Flanagan** PMHNP-BC, and **have agreed to the following terms as evidenced by my initials in each section (to ensure you review) and my signature** on the last page acknowledging these terms as you will be responsible for following them.

1. **SESSION LENGTH, CANCELLATION POLICY & SCHEDULING: Initials:_____**
    - **a.** Appt. Length:
        - **i.** Initial assessments are approx. 60 minutes in length
        - **ii.** Medication management appts. are approx. 25 minutes in length
        - **iii.** Medication management/therapy appts. are approximately 50 mins in length.
    - **b.** If I arrive late, as a courtesy to other patients,
        - **i.** within 15 minutes of my appt start time, I will have the remaining time only, left to meet.
        - **ii.** more than 15 minutes after the start time of my appt., it is considered a missed appt.
            1. I will need to be rescheduled and will be responsible for the missed appt. fee.
    - **c.** If I need to cancel an appt., advance notice is requested to prevent fee and allow that time slot to be utilized by another.
        - **i.** If I do not cancel with *at least* a day notice, OR If I miss an appt. without notice, ***I will be charged a missed appt. fee. of $85.00/per 30 min appt. and $100.00/per 60 min appt.***
    - **d.** When an appt. is missed or cancelled, I will either contact the office to reschedule by text/phone or I will use the scheduling link
2. **DISCONTINUATION OF SERVICES / CASE CLOSURE: Initials:_____**
    - **a.** If I miss more than 3 appts in 1 year, my **case may be closed** at provider discretion.
    - **b.** If I have not been seen for an appt. within 6 mos., unless scheduled as such, then my **case may be closed** at provider discretion
    - **c.** My provider may **discontinue treatment at any time** if deemed necessary by provider
        - **i.** If case closed:
            1. I will be given resources to seek new providers as necessary
            2. Medications will be cancelled at the pharmacy for the long term
            3. I will be sent refills up to 30 days (through your new provider appt.)
3. **FINANCIAL AND PAYMENT POLICY: Initials:_____**
    - **a.** My payment/co-payment is due at each appt. as designated by my insurance provider.
    - **b.** If I do not have insurance or have insurance not accepted by this provider, appt. cost is:
        - **i.** Initial- **$200.00**/appt.
        - **ii.** Medication management - **$100.00**/appt.
        - **iii.** Medication management/therapy combined- **$150.00**/appt.
    - **c.** I am responsible for the full appt. payment if my insurance fails to cover services rendered due to:
        - **i.** loss of insurance at time of appt,
        - **ii.** therapist appt. on same day as med provider
        - **iii.** deductible being due/not being met yet.
    - **d.** It is essential that I **notify my provider of any insurance coverage changes** when applicable to prevent me being responsible for the full cost of the appt.
    - **e.** I understand that my provider requires a credit card be kept on file for any charges needing payment including:

154 Waterman Street Suite 15, 3rd Floor Providence, RI 02906
Tel: (401) 251-0628 Fax: (401) 340-1580 Email: Hello@NicoleFlanaganNP.SpruceCare.com

i. missed appt. fees, co-pay, deductible, entire appt. fee.
    1. If I prefer to pay co-pays and deductible by different method, I will let office staff know

4. **PAPERWORK: Initials:_____**
    a. When paperwork needs to be completed (letters, FMLA, TDI, etc.), take note that I am a part-time provider and will need time to complete between seeing patients, working at hospital, and reviewing your records to complete your documents with complete accuracy
        i. Paperwork completion is a privilege, not a mandatory task, so please be respectful
    b. When notes are requested (usually have 30 days to send), I prefer to send a treatment summary letter rather than notes
        i. The notes have therapeutic information that these business entities (like life insurance) do not require
            1. This takes time to summarize but will get completed in the allotted time
        ii. An appt. should be scheduled to discuss the paperwork request, once you have signed a release with them, to ensure necessary information relayed
        iii. If this is an urgent request, and you require the task to be completed outside of, or before, an appt. can be scheduled/attended, then a fee may be charged. The fee will depend on the needs, but will be $50/per hour it takes for me to complete or $25/per shorter form/letter.

5. **COORDINATION OF CARE: Initials:_____**
    a. Releases: I understand that it will benefit my treatment to sign releases of information that include a(n):
        i. Emergency contact to assist if there is an emergency
        ii. Primary care provider to assist with medical concerns/coordination
        iii. Therapist (current) and/or previous psychiatric provider(s)
        iv. Current care to provide coordinated medical information
        v. EPIC (Care Everywhere) to allow coordination of care through tech network

6. **CONFIDENTIALITY: Initials:_____**
    a. I understand that any information shared in my appt. and/or in consultation sessions is confidential, with the following exceptions:
        i. If my provider assesses that I am a danger to myself or others.
        ii. If there is evidence, or it is suspected, that I am responsible for the abuse of a child or elderly person, then my provider is required by law to report this.
        iii. If my medical record is subpoenaed by a court order, then my provider must comply.
        iv. If my insurance provider requests information for treatment authorization.
        v. If I sign a release of information requesting my provider to send information to someone

7. **STUDENTS: Initials:_____**
    a. At times, students will accompany me in providing care for you. This allows me to teach new providers in order to grow community support for all.
        i. If you want to opt out, please notify your provider or initial here: _____.

8. **MEDICATIONS / PHARMACY: Initials:_____**
    a. Refills: when in need, I should contact my pharmacy for them to send requests to my provider
        i. If they are unable to for any reasons or you have not gotten response from provider in 24 hours

1. Contact provider by voicemail or text (NOT EMAIL) with at least **48 hrs. notice** of my needing the medication, to ensure that I do not go without.

ii. If I am in need, I may contact my provider for a refill but understand that if it is after hours (weekends, nights, holidays), that I will need to wait for my refills and will be appropriate

iii. Missing appts. can impact my medications:
   1. My provider has the right to **NOT renew my medications until I reschedule** my appt.
   2. If I have missed multiple appts.,
      a. Medications may not be renewed until I **actually meet with provider & pay all missed appt. fees owed.**

iv. If my case is closed, for any reason, my provider will cancel any remaining refills.

9. **STIMULANTS (Adderall, Vyvanse, etc.) / CONTROLLED SUBSTANCES (Ativan, klonopin, etc.): Initials:_____**
   a. I understand that in order to be prescribed stimulants, I must see my provider:
      i. at least every 3 mos.
      ii. in person once yearly
      iii. within 30 days of a type of stimulant change or dose change
   b. I understand that in order to be prescribed other controlled substances, I must see my provider
      i. in person once yearly
      ii. within 30 days of a type of controlled substance change or dose change
   c. If I need a refill and my pharmacy is OUT OF STOCK of my regular dose, it is my responsibility to contact pharmacies and notify my provider of what dose and what pharmacy to send the new refill to
      i. I understand that my provider may not be available at that exact time to send this in and will do so when able

10. **CONTACTING YOUR PROVIDER: Initials:_____**
   a. When my provider is unavailable, I understand that I may leave a voicemail, text, or send an email to the numbers/addresses designed (SPRUCE APP) by my provider and I will receive a response within 24-48 hours.
      i. Texting:
         1. I understand that texting (other than Spruce app) is **not** a completely secure means of communication.
         2. I understand that although texting seems like a casual way to reach my provider, that it is still to be used in a professional manner.
         3. I understand that texting should be used primarily for non-clinical/therapy purposes that include scheduling or cancelling appts.
            a. If you have clinical needs, DO NOT text asking for med changes or clinical advice via text, instead, contact office for an earlier appt. to discuss your needs.
      ii. Email:
         1. I understand that email (other than Spruce App) is **not** a completely secure means of communication.

2. Messages sent by email may not be read in a timely fashion and should not be utilized as a method of sending urgent messages.
3. Be aware that misaddressed emails cannot be retrieved.
4. Emails can be altered/falsified unlike handwritten or signed documents.
5. Messages can be forwarded without senders' permission or knowledge.
6. Back-up copies of emails can exist even after the sender/recipient has deleted their own copy.
7. Any email related to diagnosis or treatment becomes a part of the clinical record.

b. By signing this page, I consent to the risks and give permission to electronic communications.

c. I understand that when my provider is on vacation, another provider will be available for support or to advise in the case of an emergency. Their name and number will be provided on the voicemail or by the office manager at (401) 251-0628.

d. If I need **emergency support** and *cannot reach my provider*, I understand that I **should go to:**
- **i.** the nearest emergency room
- **ii.** BH link
- **iii.** Butler Hospital Inpatient Admission Center (IAC)
- **iv.** call 988 or 911

e. for less urgent outpatient support
- **i.** Butler Hospital Outpatient Evaluation Center (OEC) can assist like a walk-in center.

11. APPOINTMENT REMINDERS / PROVIDER CONTACTING ME: Initials:_____

a. I understand that appointment reminders are a courtesy provided by my provider
- **i.** Despite this, I still need to be aware of when my appointment is scheduled.
  1. I am responsible for the missed appt. fee if I miss my appt. regardless of whether the reminder system fails
- **ii.** I agree to allowing my provider, in coordination with her electronic medical record system, to send me appointment reminders by email, text or voicemail.
  1. I verbalize my preference to be noted as: **(circle one)** email / text / voicemail

Patient Signature: _____ Date: ____/____/ 20____

Witness Signature: _____ Date: ____/____/ 20____