**MILESTONE PSYCHIATRIC &**
**PSYCHOLOGICAL SERVICES, P.C.**
**(Comprehensive Psychiatric & Psychological Services**


**PSYCHIATRY**
RAJA RAO, M.D.

**PSYCHOLOGY**
ROBERT J. MAIDEN, Ph.D.
MICHELE LOWRY, PsyD
CAPRICE MURPHY. LCSW-R
LYNN O'CONNELL, PsyD
ANDREA BURCH, Psy.D

**NURSE PRACTITIONERS**
MICHELLE BENNETT, NPP PSYCHIATRY

| | | |
|---|---|---|
| **1151 Pittsford Victor Rd., Ste 103** | **15 Pleasant St.** | **PO Box 55**<br>**3460 Riverside Drive** |
| Pittsford, NY 14534 | Hornell, NY 14843 | Wellsville, NY 14895 |
| 585-593-9815 | 607-324-9240 | 585-593-1859 |
| FAX: 607-324-9744 | FAX: 607-324-9744 | FAX: 585-593-5463 |


## PLEASE PRINT CLEARLY

**Client: _____**
Last Name First Name Middle Initial

**DOB: ____/____/____ Sex: M ____ F ____ E-Mail:_____**
**(list only if you agree to correspondence from Milestone)**

**Address: _____ PO Box _____**
Street
_____ _____ _____
City State Zip Code

**Primary Phone: (_____) _____ Can we leave a message? YES _____ NO_____**

**Employer: _____ Student: _____ Not Employed: _____**

**Primary Care Physician: _____ Phone: _____**

**Pharmacy Name: _____ Phone: _____**

**Emergency Contact: _____**

**Phone: _____ Relationship to Patient: _____**

**Referring Doctor/ Source: _____**

**Insurance Name: _____ Member ID: _____**

**Subscriber: _____ Subscriber DOB: ____/____/____**

**Relationship to Patient: _____**

***** please note if there is additional insurance coverage *****
**Patient Name: _____ DOB: _____**

**Presenting Problem:**
What is the main concern that prompted you to make this appointment?

_____
_____
_____
_____

**Psychiatric and Psychological History:**
Provide all past mental health and substance abuse treatment, including outpatient and inpatient.

_____
_____
_____

**Medication History:**
List all current psychiatric medications:

| DRUG | DOSE | FREQUENCY | PRESCRIBING PHYSICIAN |
|---|---|---|---|

_____
_____

Past Medications:_____

List current medications other than psychiatric:

| DRUG | DOSE | FREQUENCY | PRESCRIBING PHYSICIAN |
|---|---|---|---|

_____
_____
_____

List any **non**-prescription medications:

_____
_____
_____

**Medical and Surgical History—Past/Present**

_____
_____
_____

**Social History (If a child, marital status of parents)**
Marital status: Single ____ Married ____ Widowed ____ Divorced ____ Separated ____ Partnered _____
Name: _____

**Children (if a child, please list siblings)**

| Name | Age | Location | Custody (Joint/ Single, etc) |
|---|---|---|---|

_____
_____
_____
_____

**Pertaining to children who will be seen:**
Lawyer:_____ phone:_____
Law Guardian: _____ phone: _____
School Counselor: _____ phone: _____

**Patient Name: _____ DOB: _____**

## Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our payment policies.

1. Insurance: We participate in most insurance plans, including Medicare. If you are insured by a plan we do business with but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

2. Co-payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. For your convenience we accept MasterCard and Visa. **You will be billed a $15 handling fee for not paying your co-pay at the time of service unless other arraignments have been made.**

3. Non-covered Services: Be aware that some and perhaps all of your services you receive may be non-covered or not reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.

4. Proof of Insurance: All patients must complete out patient registration form before being seen. We must obtain a copy of your current valid insurance card to provide proof of insurance. **If you fail to provide us with the correct insurance information in time to meet your insurance company claim filing limit, you will be responsible for the balance of the claim.**

5. Claims Submission: We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage Changes: If your insurance changes, please notify us so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Non-payment: If your account is over 30 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payment will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternate medical care.

8. NO SHOW Fees: **The number of patients requiring services dictates the use of time responsibly.** Please be advised of the institution of a no show fee for failure to come to a scheduled appointment without at least 24 hours prior notice with the exception of an emergency. This fee cannot be billed to an insurance company and is due prior to your next appointment. We reserve the right to not reschedule future appointments.

| | |
|---|---|
| PsyD/ PhD | $40.00 (16-37 min)/ $80.00 (38-or more min) |
| MD/ FNP | $60.00 |

**Patient Name: _____ DOB: _____**

**Professional Fees**

The fee for an initial visit is $230.00. Subsequent 16-37 minute session $103.00, 37-50 minute sessions are $166.00, and 53-60 minute session is $269.00, and medication management visits are $110.00. You may be eligible for a sliding-scale self-pay rate, please inquire with the receptionist.

Professional services that you may request and/or require, including written reports, consultation with other professionals (with your informed consent), and telephone, fax, and/or e-mail communications which become excessive and beyond the scope of reasonable services, will be billed at $161.25/hour accrued in 15 minute intervals.

If you become involved in legal proceedings that require participation, you will be expected to pay for all professional time, including preparation, travel, and attendance at any legal proceeding. Due to the complexity of legal proceedings and time away from client hours, the hourly rate is $250.00, accrued in 15 minute intervals.

Occasionally, it may be advisable to administer self-report rating scales and/or other social-emotional and psychological measures. You should be aware that your insurance company may not cover the cost for the administration and scoring of these assessment measures. In addition, psycho educational assessments may not be covered by your insurance company. Rates for these types of psychological testing are generally $174.00 per unit. Specifics and financial arrangements should be discussed prior to service.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area. Let us know if you have any questions or concerns.

**I have read and understand the Financial Policy and Professional Fees and agree to abide by these guidelines:**

_____

Signature of patient (or responsible party, if minor) Date

**Prescription Refill Policy**

When you have a prescription that needs to be refilled, please do the following:

1. Please call the office at least 7 -10 days in advance. Failure to do so may result in you not getting your prescriptions filled in a timely manner.

**ALL prescriptions need approval from Dr Rao/ Michelle Bennett before they can be obtained.**

Please have all applicable information ready for the receptionist when calling (prescription name, pharmacy, etc).

_____

Signature of patient/ responsible party Date

**Patient Name: _____ DOB: _____**

**Informed Consent for Treatment**

Clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be releases to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as described in the **NOTICE OF PRIVACY PRACTICES** below. Please do not hesitate to ask questions.

Entering mental health treatment is a courageous step. You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. You may be asked to participate in activities and tasks outside the sessions held here. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about treatment. You will be involved in the process of designating and implementing, and the periodic review, of your treatment plan. You have the right to be informed of your mental health diagnosis after the mental health assessment is completed, and the purpose of any prescribed medication and potential side effects. You also have the right to withdraw consent and terminate services at any time. If you have any questions about the nature if your treatment, talk directly to the doctor you are seeing as soon as the question arises.

**I authorize Milestone PPS, PC to release given info to my listed insurance company, information from my records relating to the identity, diagnosis, and treatment for the purposes or needs of payment.**

_____

Signature of patient/ responsible party Date

# HIPAA

I have reviewed the HIPAA privacy statement.

_____

Signature of patient/ responsible party Date

## Call Reminder Notification:

Please be advised that Milestone utilizes a call reminder system as a courtesy to patients. Please NO NOT depend on these calls, as there is the possibility of system malfunction. Milestone is not responsible for missed appointments due to the call reminders not being received, or malfunctioning. Thank you.