



**Uptown Psych**

4753 N. Broadway St. Suite 403

Chicago, IL. 60640

820 Davis St, Suite 222

Evanston, IL 60201

Phone: 773-989-2780

Fax: 773-989-2781

**CONSENT TO BE CONTACTED FOR POST-VISIT SATISFACTION SURVEY FORM**

**Patient First Name:** \_\_\_\_\_

Patient Last Name: \_\_\_\_\_

**Patient Date of Birth:** \_\_\_\_\_

Uptown Psych is committed to ensuring patients' satisfaction of services received. Center has contracted with a third party – Burke, Inc. – to conduct satisfaction surveys on our behalf. The survey will be provided online and will take no more than 10 minutes to complete. If you agree to be contacted to participate in a survey about our services, please indicate your consent by checking one of the boxes below:

I agree to be contacted by Burke, Inc. via email (at the email listed below) for purpose of the survey and understand that the invitation will mention Center. I acknowledge and agree that these messages, which may contain Protected Health Information, will be sent via unencrypted means and there is some risk of disclosure or interception of the messages.

Email Address: \_\_\_\_\_

I understand that this consent may be withdrawn by me at any time via the email I receive from Burke, Inc., via telephone by calling **773-989-2780** or via email message at [info@uptownpsych.com](mailto:info@uptownpsych.com) I understand that my withdrawal of consent to be contacted for a post-visit satisfaction survey shall not withdraw my consent to otherwise be contacted by Center.

I do not wish to be contacted for purposes of this survey.

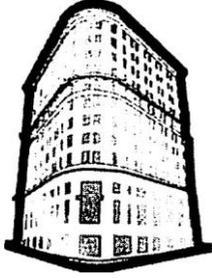
**Signature**

I confirm that I have read and fully understand the above information prior to my signing and all of my questions regarding this form have been answered to my satisfaction. I agree that I am signing this Consent to be Contacted for Post-Visit Satisfaction Survey Form freely and voluntarily. I understand that my consent given with my signature below will remain in effect unless and until I cancel such consent in writing pursuant to the terms set forth above.

Signature of Patient or Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient (or Responsible Party): \_\_\_\_\_

Responsible Party's Relationship to Patient: \_\_\_\_\_



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[info@uptownpsych.com](mailto:info@uptownpsych.com)

[www.uptownpsych.com](http://www.uptownpsych.com)

**Intake Form**

Patient \_\_\_\_\_ Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Legal Name (if different from above)

\_\_\_\_\_

SSN: \_\_\_\_\_

Birth Gender \_\_\_\_\_ Gender Identity \_\_\_\_\_

Marital Status:      Married      Single      Divorced      Widowed      Separated

Physical Address

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Is Mailing Address the same? Yes      No

Mailing Address

\_\_\_\_\_

City: \_\_\_\_\_

State; \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Insurance Information (Patients under 26 that have insurance under parents, please sign ROI form for billing communication)

Insurance Provider: \_\_\_\_\_ Identification #: \_\_\_\_\_

Group #: \_\_\_\_\_ Policy Holder Name \_\_\_\_\_

Policy Holder DOB \_\_\_\_\_ Policy Holder SSN \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_

Insurance Provider: \_\_\_\_\_ Identification#: \_\_\_\_\_

Group #: \_\_\_\_\_

From whom or where do you receive your primary medical care?

From whom or where do you receive your primary medical care?

Clinic[Doctors Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Are you currently receiving psychiatric services, professional counseling or psychotherapy elsewhere? \_\_\_\_\_ Yes No

If Yes, by whom: \_\_\_\_\_

Emergency Contact

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Pharmacy Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

How did you hear about us: \_\_\_\_\_

Would you be interested in learning more about trans-cranial magnetic stimulation (TMS), an FDA cleared, non-drug, side-effect free treatment for depression?

Yes No

**Office Financial Policy**

Self-Pay Services Only:	Discounted Rate Fees	Out of Network Fees \$400
Initial psychiatric evaluation -- up to 60 minutes	\$400	\$400
Follow up psychiatry appointment -- 15-30 minutes	\$175	\$265
Initial therapy service --1 hour	\$135	\$300
Therapy service -- 1 hour	\$135	\$200
Group therapy — 1 hour	\$80	\$100
Family/Couples therapy —1 hour Miscellaneous	\$135	\$165
Fees:		
Initial visit no show fee	\$150	
Follow-up no show fee	\$100	
Lost controlled substances prescriptions	\$25	
Refill (Future appointment must be scheduled)	\$15	
Letters or medical records	\$20-\$150	

Self-Pay Discounted Policy:

- I understand that because I am being offered a discounted price for services, I will not be provided claim information to submit to my insurance for reimbursement. Out of Network Reimbursement Policy:
- I understand that it is my responsibility to submit any claims to my insurance company for reimbursement.
- I understand that it can take up to a week to be provided an itemized receipt for my visit.
- I understand that I am being charged \$265 upfront for psychiatry follow ups. Depending on the services provided that can range from \$100-\$300. If any differences in charges are found, the office will bill/refund me.

Signed

Date

\_\_\_\_\_

Patient/Guarantor

\_\_\_\_\_By signing above, the patient or guarantor acknowledges that he/she has read and agrees to comply with all policies above

### Office Financial Policy

#### Cancellation/Missed Appointment Policy:

- Failure to show up to an appointment without 48 hours' notice will be subject to a \$150.00 (initial) or \$100.00 (follow up) charge.
- Cancellations made at the time or after a scheduled appointment will be considered as a missed appointment and card on file will be charged.

#### Individual Financial Responsibility:

- Uptown Psych will verify benefits prior to an appointment but a quote of benefits is not a guarantee of payment.
- I understand that the amount that is calculated at the time of my appointment is an estimate and depending on what is billed by my provider, there might additional be credit or balance after the service.
- I understand that it is my responsibility to provide the office with any changes of insurance coverage prior to my visit or I will be charged the self-pay rate until benefits are verified. • I understand that in the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- I understand that copays/deductible/coinsurance are due at time of service and any outstanding balances need to be paid prior to being seen.
- I understand that if payment cannot be made, my current/future appointments will be cancelled until full payment is received.
- I understand that I am financially responsible for any copay, deductible, coinsurance or non-covered service and may be contacted by email or phone call/text message.
- I understand that Providers may access records for administrative reasons.
- I consent to electronic signature with credit card swiped.

I agree that refunds will be sent by check and the process can take up to 45 days I authorize Uptown Psych to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays, deductibles and/or coinsurance after all attempts Uptown Psych has made in collecting the balance.

Signed \_\_\_\_\_

**Phone Consultation & Documentation Requests Policy**

As a reminder, phone calls to your provider should be for emergency purposes only. All other matters are best discussed in session. In order to provide you with the best care, with your permission, our clinicians may communicate with other providers or collect outside information.

At times, this information may be beneficial and inform your treatment.

Scheduling an appointment with one of our psychotherapists to complete any ancillary paperwork or discuss collateral information is highly recommended. For our psychiatrists, appointments for these purposes are absolutely required. Please note, phone contact that our psychotherapists have with outside providers and paperwork completion time are not payable by your insurance company. These services may be billed directly to you from the fee schedule below.

Requests for documentation are granted on a case-by-case basis at the sole discretion of your provider. Typically, several sessions and consistent engagement in treatment is required for a provider to feel comfortable providing documentation of any kind. Beneficial information sources by phone include, but are not limited to:

Outside providers such as past individual therapists or Psychiatrists, group therapy counselors, social workers, and psychological testing specialists. For minors, teachers, school psychologists or social workers, and Individualized Education Plan or 504 involved specialists can also be helpful.

Documentation requests can include, but are not limited to:

Clinical summaries of diagnostic impressions or treatment plans, FMLA (Family Medical Leave Act) paperwork completion, background check documents for employment, bariatric surgery candidate requirements, letters to verify work absences for mental health reasons, documentation to show attendance of mental health appointments (sometimes required for court ordered treatment and minors involved with Department of Child and Family Services), disability paperwork, and summaries of clinical recommendations or impressions as requested by outside medical professionals.

Rates for phone consultation: \$75.00

Rates for documentation completion: \$60.00

Signed

Date

\_\_\_\_\_

**Credit Card on File Form**

**Uptown Psych** requires that you provide a **credit card on file** with our office. **Credit Cards on file** will be used to pay account balances and Credit **cards** will be charged at the time of service for your patient responsibility.

Visa	MasterCard	Amex	Discover
Card Number	_____		
Expiration Date	_____		
CVV Code	_____		
Name on Card	_____		
Address	_____		
Zip Code	_____		

I understand that this form is valid without expiration unless I cancel in writing.

Signed	Date
_____	_____
Patient/Guarantor	

**Email Policy**

To better serve our patients, this office has established an email address for some form of communication. For routine matters that do not require response, please feel free to contact us at [info@uptownpsych.com](mailto:info@uptownpsych.com). Please remember however, that this form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 12 hours. The service provider may delay message delivery. Should you require urgent or immediate attention, this medium is not appropriate.

When sending email, please put the subject of your message in the subject line so we can process it more efficiently. Also, be sure to put your name, patient ID number and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from this office by using the auto reply feature.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property, and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff and/or colleagues would have access to this information.

\_\_\_\_\_I understand that this office will not be responsible for information loss or delay, or breaches in confidentiality that are due to technical factors beyond this office's control.

\_\_\_\_\_I understand and agree that we may send medical related correspondence to you via email, and that we may respond to your emails to us via email.

\_\_\_\_\_  
Patient signature

\_\_\_\_\_  
Witness (optional)

\_\_\_\_\_  
Date

## Email Policy

When requested this office will communicate some forms of information via email. This medium will be used with an eye towards medical and legal prudence.

- Email communications will only be used with established patients.
- Patients who elect to use email must be advised of this office's email policy and sign an informed consent (see attached).
- A copy of the consent will be given to the patient, if requested and another copy will be filed in the patient medical record. ● Email communications are restricted to conditions and situations which do not require immediate attention (see consent).
- Protected health information [ PHI ] will be transmitted in a secure format to render the information unusable, unreadable or indecipherable to unauthorized individuals.  
[http://csrc.nist.gov/publications/nistpubs/800-66-Rev1-SP-800-66-Revision1 .pdf](http://csrc.nist.gov/publications/nistpubs/800-66-Rev1-SP-800-66-Revision1.pdf)
- Email communications are a permanent part of the patient medical record. They should be retained in the paper record and/or electronically consistent with the Illinois medical records retention rules <http://www.ilga.gov/legislation/ilcs/fulltext.asp?DocName=021000850K6.17>
- When a patient request has been completed, the staff member responsible for completing that task will be responsible for sending a confirmation message to the patient.
- As with any form of medical record documentation, unprofessional remarks or comments in email communications are prohibited.
- Confidentiality of patient information will be maintained at all times to protect the integrity of patient-identifiable information.
- When sending patient information via email, the sender is expected to double check all "To" fields before transmitting.
- Maintaining a master list of patients email addresses is discouraged.
- Outgoing messages will contain discreet subject headers and a banner at the top of each message stating, "This is confidential medical communication."
- Each desktop workstation will have a password protected screen saver.

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Patient signature

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Witness (optional)

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Date

**HIPAA Consent**

This form is an agreement between you and Uptown Psych. When we use the words "you" and "your" below, this can mean you, your child, a relative, or some other person if you have written his or her name here:

\_\_\_\_\_

When we examine, test, diagnose, treat, or refer you, we will be collecting what the law calls "protected health information" (PHI) about you. We need to use this information in our office to decide on what treatment is best for you and provide treatment to you. We may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you. By signing this form, you are also agreeing to let us use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our notice of privacy practices, which explains in more detail what your rights are and how we can use and share your information.

If you do not sign this form agreeing to our privacy practices, we cannot treat you. In the future, we may change how we use your information, how we share your information, and may change our notice of privacy practices. If we do change it, you can get a copy from our website, [www.uptownpsych.com](http://www.uptownpsych.com), or by calling us at (773) 989-2780. If you are concerned about your PHI, you have the right to ask us not to use or share some of it for treatment, payment, or administrative purposes. You will have to tell us what you want in writing and have it submitted to us. Although we will try to respect your wishes, we are not required to accept these limitations. However, if we do agree, we promise to do as asked. After you have signed this consent, you have the right to revoke it by writing to our privacy officer. We will then stop using or sharing your PHI, but we may already have used or shared some of it, and we cannot change that.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient: \_\_\_\_\_

If Patient is under 18 years of age:

Signature of Parent/Guardian: \_\_\_\_\_

Printed Name of Parent/Guardian: Relationship to Patient: \_\_\_\_\_

### **Patient Responsibilities**

All required patient forms must be completed and returned to front office staff before the time of your appointment; otherwise, the appointment may need to be rescheduled.

1. Patients are responsible for knowing what medications they are currently taking when scheduling an appointment. Some practitioners may not be able to provide certain medications and patients should be aware of this in advance.
2. Individual practitioners also may have different limitations and restrictions as to what they are able to prescribe with regards to controlled substances. These policies may be further outlined in the accompanying paperwork. If provided in advance, it is the patient's responsibility to be familiar with these policies as they will not change during the course of the appointment.
3. If additional paperwork is being requested from the provider such as FMLA, short term disability, emotional support animals, court documents etc., it is the patient's responsibility to discuss this in advance, provide the appropriate forms, and understand that certain requirements may need to be met for the provider to fill out such forms, and understand that certain requirements may need to be met for the provider to fill out such forms, if able to do so at all. Before being considered for such requests, patients need to be established (e.g. have been seen for multiple appointments with engagement in care). In addition, paperwork completion is subject to additional fees varying from \$25 to \$200.
4. Missed appointments and cancellations less than 48 hours in advance, including initial evaluations, will be subject to a standard cancellation fee. The cancellation fee may be waived one time for an excusable or emergency situation, at the discretion of the provider. All subsequent missed appointments or cancellations (less than 48 hours in advance) will be subject to the standard fee without exception. Missed appointments beyond the third may result in transfer of care or care termination of the case as patients are expected to maintain appropriate follow up care as recommended by their provider.
5. Arrival to an appointment either in-person or virtual should be made in a timely manner. Beyond a certain period, your appointment may need to be rescheduled as having a significantly shortened appointment may not be therapeutic to treatment, and providers make their best efforts to provide each patient with their allowed time so as not to take away from the time of the next scheduled patient. Your appointment may need to be rescheduled if you arrive more than 10 minutes late to an intake appointment or more than 5 minutes late to a follow up appointment.
6. Refills for medications are completed during appointment times. Parents are responsible for scheduling follow up appointments in a timely manner such as they do not run out of medications. For all refill requests outside of appointments, patients are required to have an upcoming appointment scheduled. A partial refill until the upcoming appointment may be considered at the discretion of the provider, subject to a \$20 charge.

7. **Providers may take 48 hours (2 business days) to return messages and phone calls.** If it is an urgent matter or an emergency, please call 911 or go to the emergency room.
8. If a patient has not been seen for 6 months or more, they will be considered inactive and their case at Uptown Psych will be closed.
9. If patients email their providers, they should send a separate email regarding each matter and not send multiple emails regarding same issue.

Patient signature \_\_\_\_\_

Date \_\_\_\_\_

## **YOUR INFORMATION. YOUR RIGHTS. OUR RESPONSIBILITIES.**

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

### Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

### Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition • Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information • Raise funds

### Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests • Respond to lawsuits and legal actions

### Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary

of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

#### Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

#### Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

#### Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

#### Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

#### Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

#### Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

#### File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1877-696-6775, or visiting [www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/). • We will not retaliate against you for filing a complaint.

## Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases, we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

## Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways. Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways — usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: [www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html).

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

#### Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

#### Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

#### Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

#### Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

#### Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

#### Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see:

[www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html](http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html).

#### Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

#### Other Instructions for Notice

- If you have concerns, contact the Privacy Officer with Uptown Psych at 773-989-2780 • We never market or sell personal information

## **Patient Information and Consent Form for Telepsychiatry**

This consent form for telepsychiatry is entered into on \_\_\_\_\_ (date) by \_\_\_\_\_ (patient) and \_\_\_\_\_ (Uptown Psych Treating Provider)

### **Introduction**

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist or nurse (provider) and the patient are not in the same location. The interactive electronic systems used in telepsychiatry incorporate network and software security protocols (encryption) to protect the confidentiality of patient information and audio and visual data.

### **Potential Benefits of Telepsychiatry**

- Increased accessibility to psychiatric care.
- Patient convenience.

### **Potential Risks with Telepsychiatry**

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate medical decision making by your Uptown Psych Treating Provider
- Your Uptown Psych Treating Provider may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or range for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, (although extremely unlikely) causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face-to-face visit but not in telepsychiatry session may result in errors in medical judgment.

### **Alternatives to the use of Telepsychiatry**

- Traditional face to face sessions in your Uptown Psych Treating Provider's office.

### **Confidentiality Standards required for Telepsychiatry**

- During a tele mental health session, both locations shall be considered a patient examination room regardless of a room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the Doctor and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the exam room at both sites shall be identifiable to all participants prior to the consultation and the patient's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for telepsychiatry as for face-to-face consultations.

**My Rights**

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2. I understand that the video conferencing technology used by my Uptown Psych Treating Provider is encrypted to prevent unauthorized access to my private medical information.
3. I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time. Understand that my withdrawal of consent will not affect any future care or treatment.
4. I understand that my Uptown Psych Treating Provider has the right to withhold or withdraw their consent for the use of telepsychiatry during my care at any time.
5. I understand that all rules and regulations which apply to the practice of medicine in the state of Illinois also apply to telepsychiatry.
6. I understand that my Uptown Psych Treating Provider will not record any of our telepsychiatry sessions without my prior written consent.

**My Responsibilities**

1. I will not record any telepsychiatry sessions without prior written consent from my Uptown Psych Treating Provider.
2. I will inform my Uptown Psych Treating Provider if any other person can hear or see any part of our session before the session begins. My Uptown Psych Treating Provider will inform me if any other person can hear or see any part of our session before the session begins.
3. I understand that third parties may be required to join in the meeting with my doctor and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use telepsychiatry.
4. I understand that I, not my Uptown Psych Treating Provider, am responsible for the configuration of equipment on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third-party (Secure Telehealth) for technical support to determine my computer's readiness for telemedicine prior to beginning tele psych sessions with my doctor.
5. I understand that I must be a resident of the state of Illinois to be eligible for telepsychiatry services from my Uptown Psych Treating Provider

**Patient Consent to the use of Telepsychiatry** have read and understand the information provided above regarding telepsychiatry and have discussed it with my Uptown Psych Treating Provider and all of my questions have been answered to my satisfaction.

Signature of Patient (or person authorized to sign for patient):

Full name \_\_\_\_\_ Signature \_\_\_\_\_ Date: \_\_\_\_\_

I authorized signer, relationship to patient: \_\_\_\_\_

\_\_\_\_\_

Uptown Psych Treating Provider

**PLEASE COMPLETE IF YOU ARE SEEING DR. LAM, DR. DESAI, DR. SHARMA, DR. NGUYEN, OR SIENA MAY**

Controlled substances are medications which include, but are not limited to the following:

- Certain sleep medications (Ambien, Lunesta, Sonata, etc. and their generics)
- Benzodiazepines (xanax, ativan, valium, librium, klonopin etc and their generics) • Stimulants (Adderall, vyvanse, concerta, ritalin, modafinil etc and their generics)
- Suboxone – Provider is not licensed to prescribe and thus does not prescribe.

**Updated Controlled Substances Policy:**

1. Provider does not prescribe multiple controlled substances to any patient. If you are taking more than one of these medications, it is your responsibility to have a primary care doctor or alternative provider to continue the other prescription. It will not be filled by provider during the course of treatment at any time.
2. All patients are required to complete and provide documented results of completed neuropsychological testing prior to starting any stimulant medication. This is NOT the same as an ADHD evaluation, ADHD screening, ADHD test, etc. Anything else submitted will still require completion of neuropsychological testing before stimulants can be started. Resources are provided below.
3. Upon starting or continuing any controlled substance prescription, a 6 month trial period will begin at which time medications may be titrated to effective dosing within provider specified limitations (see below). During this 6 month period, the patient will be responsible for finding either a primary care or alternative provider to continue the prescription beyond the 6<sup>th</sup> month. These medications are not designed to be taken in perpetuity so while Dr. Desai acknowledges that a number of patients will benefit from long term usage beyond this period, it is not a regimen that he prescribes. There are many well established physicians who will gladly continue these prescriptions outside of the office that can be contacted.
4. Provider does not prescribe more than a 1 mg equivalent of any benzodiazepine for emergency or daily use. If you are currently taking or feel you will need more than this amount, please let the office staff know so that you can be transferred to an alternative provider to better fit your needs.
5. Provider does not prescribe more than 40 mg TOTAL daily of any stimulant medication. If you are currently taking or feel that you will need more than this amount, please let the office staff know so that you can be transferred to an alternative provider to better fit your needs.
6. If you are a patient who is being transferred from a provider within the practice and currently taking stimulants, you may be seen for up to a 3 month grace period for refills. Within this time period it is your responsibility to complete and submit neuropsychological testing as is required of any other patient.  
Alternatively, you may use this time to establish care elsewhere to continue your prescription. Regardless, no more than 40 mg as described above will be provided, and after the third month, no prescriptions will be written without completed neuropsychological testing.
7. Prescriptions are written on a month-by-month basis and only for one month at a time. If a prescription or medications are lost, the patient may receive one emergency refill, but this will be up to the pharmacist's discretion to fill. No further emergency or early refills will be provided beyond this single instance.

8. These policies remain subject to change and do not constitute a guarantee that you will receive a controlled substance prescription at any point in time.

I have read the above, understand, and agree to abide by the controlled substance policies as stated above by provider.

---

Signature

**NeuroPsych Resources**

Please contact any of the following for **Neuropsychological Testing**:

Denise Fiduccia ADHD

Mary Schmidt ADHD

Athen's and Associates ADHD

Ellen Kraemer ADHD

George, Miller, White and Associates ADHD

Gersten Center for Behavioral Health ADHD

Belmont Depression and Anxiety Center

Kim Rubenstein, Psy.D. Center for Personal Development

Cognitive Solutions Learning Center Sharon Getz, Psy.D.

Frederick Bylsma Ph.D. Neuropsychological Services, P.C.

Psychologytoday.us

**PSYCHIATRY HEALTH HISTORY FORM**

Date:

Name:

Reason for visit today:

Past Medical History:

Current medical conditions:

Current medications:

Allergies:

Past Psychiatric History:

History: History of counseling/therapy: (Indicate when, where, name of counselor)

Previous trials of psychiatric medications:

Previous psychiatric hospitalization: (Indicate when and where)

## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems? (Use "V" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

FOR OFFICE CODING

\_ 0 \_ + \_ \_ \_ + \_ \_ \_ + \_ \_ \_

Total Score: \_\_\_\_\_

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
difficult

Somewhat difficult

Very difficult

Extremely

**PLEASE COMPLETE IF YOU ARE SEEING DR. MORRILL**

**CONTACTING DR. MORRILL BETWEEN APPOINTMENTS**

**1) Refill requests**

Refills are normally provided at the time of our appointment. As a general rule, I provide enough refills to last until the time of our next scheduled meeting.

I do understand that, from time to time, you may need me to authorize a refill between appointments. (For example, you may have missed or postponed an appointment). Here are some guidelines about how to handle these situations:

- \* Please **do not** rely on your pharmacy to contact my office with a refill request. Pharmacies tend to be unreliable in this regard. (For example, it is not uncommon for them to send refill requests to the wrong clinic).
  
- \* Please **do** check your medication bottle or check with your pharmacy to see if you already have refills waiting, before you request one.
  
- \* Medication refills may be requested by contacting the front desk (773 989 2780) during office hours (8-8 M-F and 8-5 Saturday). Please allow one full business day for me to respond to these requests. If the issue has not been resolved after one business day, please feel free to re-contact the office.
  
- \* Refill requests incur a charge of \$15 (or \$25 for controlled substance refills). This fee is waived if the refill request stems from factors outside of your control (e.g., if you missed an appointment due to illness) or if it would pose a financial hardship.

**2) Issues other than refill requests**

Please note that the office number is not intended for emergency use. **If you are experiencing a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.**

If you have a concern or a brief question about one of your medications, please feel free to contact the office during business hours. For example, I would encourage you to call the office for the following issues:

- \* you are experiencing adverse effects from a medication which do not constitute a medical or psychiatric emergency, but which you would like to discuss promptly
  
- \* you are unclear about the directions on how to take a medication
  
- \* your pharmacy was unable to fill a prescription (e.g, due to an insurance issue)
  
- \* you have a documentation request (e.g. requests for FMLA, medical records, or documentation for an emotional support animal)

\* another physician or therapist is trying to contact me regarding your care

If you are in doubt as to whether your issue or concern warrants a phone call... please call.

Please allow one full business day for a response to these inquiries. If you have not received a response within one business day, feel free to re-contact the office. Note that requests for complex paperwork (e.g., FMLA requests) may require additional time.

Please also note that the assistance I can offer during a between-appointment phone call is limited. I cannot provide psychotherapy services between appointments. I also cannot make major changes to medications, or start a new medication, outside of an appointment. In my experience, it is preferable to make major medication changes during a scheduled appointment, in order to ensure that we both have an uninterrupted block of time during which we can discuss the issue in detail and without distractions.

If you are experiencing a more complex issue which you feel may require significant changes to your medications or treatment plan, I recommend that you contact the office and request the earliest available appointment that works with your schedule. In the majority of cases, we are able to schedule an appointment with established patients within one week or less.

I have read and understood the above guidelines and am in agreement with these guidelines.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## **DR. MORRILL'S POLICIES REGARDING CONTROLLED SUBSTANCES**

### **I. BENZODIAZEPINES**

**Benzodiazepines** are a class of anxiety-reducing medications which includes Klonopin (clonazepam), Ativan (lorazepam), Xanax (alprazolam), Valium (diazepam), Restoril (temazepam), and a few others. All benzodiazepines are classified by the FDA as controlled substances due to their potential for abuse and dependence.

As a general rule, I do not prescribe benzodiazepines on a long-term basis. This is because I do not feel that they are either safe or effective as a long-term treatment for anxiety or other mood disorders. This opinion is based both upon my reading of the medical literature and my years of clinical experience. I will be happy to discuss my reasoning with you in session, and also to discuss the applicable research literature and clinical guidelines, if this is a topic of interest to you.

If you are currently taking one or more benzodiazepines and you choose to enter treatment with me, a goal of treatment will be to taper and discontinue these medications, and to find other strategies for managing your anxiety symptoms.

The process of tapering is usually gradual and may take a period of weeks or months. Over the years, I have helped many people successfully taper off benzodiazepines, in a manner designed to minimize any withdrawal effects. In most cases I have noticed that the patient experiences improvement of symptoms and greater mood stability after these medications have been stopped.

Note that there is one minor exception to the “no benzos” policy. Occasionally, I will encounter a patient with a specific phobia that is not triggered very often (e.g. fear of flying, fear of needles, fear of getting a medical procedure such as an MRI). For these patients I will sometimes prescribe a very limited supply of benzodiazepines to be used exclusively for situational anxiety, e.g. a dose of Ativan prior to a plane flight. In these cases, the use of benzodiazepines is typically very infrequent (e.g. a few times a year).

## II. STIMULANTS

**Stimulants** are a class of medications which are commonly prescribed for ADHD (and occasionally for other disorders). Examples include Adderall, dextroamphetamine, Ritalin, Concerta, Focalin, Vyvanse, and a few others. Like the benzodiazepenes, these medications carry a substantial risk of abuse or dependence and are classified by the FDA as controlled substances.

**Please be aware that I prescribe stimulant medications very selectively.** Like many of my colleagues, I believe that these medications are currently over-prescribed. Over the past 25 years, the use of stimulant medication in the United States has increased by **nearly 500%**. I believe that this increase has been largely driven by financial and sociological factors, and not by clinical necessity.

If you are a prospective patient who is concerned about issues with focus or attention, you should be aware of the following considerations:

- (1) The diagnostic criteria for ADHD (as outlined in the DSM-V) are notoriously subjective. Physicians frequently disagree with each other about whether a specific patient meets criteria for ADHD. Thus, the fact that you have been previously diagnosed with ADHD by another physician does not guarantee that I will arrive at the same diagnosis.
- (2) Patients often come to my office stating that they “want to be tested for ADHD” (or, in some cases, stating that they have already “been tested for ADHD”). Unfortunately, there is **no** standardized test available which either definitively confirms, or definitively rules out, a diagnosis of ADHD. Psychiatrists do sometimes order “neuropsych testing” during their evaluation of ADHD patients. Although these tests may be of some value in identifying problem areas, there is an extensive body of research which shows that they do not correlate well with the presence or absence of ADHD.
- (3) Problems with attention/focus are often caused, in whole or in part, by clinical issues other than ADHD. Examples include 1) the concurrent use of sedating or cognitively impairing medications, and 2) the presence of undiagnosed or untreated sleep apnea. (There are many other causes of attentional problems, which I will be happy to

discuss with you in session). My goal as a physician is always to identify and address these issues **before** considering a course of treatment with stimulant medication.

Please note that if you are currently taking a medication which is known to cause significant issues with focus/attention (e.g. a benzodiazepine), I will not be able to prescribe stimulant medication.

When I do prescribe stimulants, I make efforts to prescribe the lowest effective dose and encourage patients to take “breaks” from stimulant use whenever possible (e.g., on weekends or vacations). I also encourage patients to periodically re-evaluate their attentional symptoms and to re-evaluate whether there is an ongoing need for stimulant medication.



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Fax: 773-989-2781  
info@uptownpsych.com  
www.uptownpsych.com

## TMS Treatment

**Welcome to Uptown Psych,**

**Here at our office, we offer a TMS (transcranial magnetic stimulation). This is a treatment that is reviewed by a psychiatrist and performed by a TMS technician. This treatment is also covered by most insurance companies.**

### **HISTORY**

TMS has been approved by the FDA for the treatment of depression since October 2008. The interest in magnetic fields started in the mid 1980's for evidence began showing they possessed potential therapeutic value.

The first controlled trials in North America started in 1999 and since then many subsequent trials and clinical experiences have further elucidated the therapeutic value of using Transcranial Magnetic Stimulation as a tool in the treatment of depression.

In December 2010 the American Psychiatric Association guidelines in the treatment of depression were modified to include TMS as an appropriate treatment to consider after failing at least one adequate trial of antidepressants.

### **HOW DOES IT WORK?**

During a TMS treatment session, an electromagnetic coil is placed against your scalp near your forehead. The electromagnet painlessly delivers a magnetic pulse that stimulates the nerve cells; In the region of your brain involved in mood control and depression/anxiety. It's thought to activate regions of the brain that have decreased activity in depression. The stimulation appears to impact how the brain is operating, which in turn seems to ease depression symptoms and improve mood.

**GET STARTED TODAY** Please check the box below if you are interested in starting this treatment You can also visit our website **Uptownpsych.com** and fill out our **Treatment Resistant Questionnaire**.

**Yes, I would like more information.**