CAPS
Child & Adolescent Psychiatric Solutions

Policies

Thank you for choosing Child and Adolescent Psychiatric Solutions as your mental health provider. We are committed to providing you the highest quality care available. Your psychiatric/psychological evaluation is taken very seriously as ample time is set aside to get to know you, answer questions, and discuss treatment options. The following is a summary of our policies, which we require all patients to read and sign prior to their treatment.

Scheduling Appointments

If you are receiving psychiatric care through Child and Adolescent Psychiatric Solutions, we require you to receive therapy as well. You will need to maintain ongoing therapy in combination with medication management. Evidence-based care has shown that a combination of therapy along with medication management provides the best results, and as such, this is what we will provide. Please bring all records from previous providers (discharge paperwork, IEPs, RRs, evaluations, testing, etc.) to your first appointment. Failure to do so can cause a delay in comprehensive assessment and may delay start of treatment. Follow-ups should scheduled with your clinician during your appointment or through the main office by phone.

Contacting Your Clinician

Due to the timing of sessions, we are not always personally available by phone or email. Every effort will be made to return your call or email as soon as possible. Clinician phone calls will be limited to administrative purposes, adverse medical reactions, consultation with schools, or collaboration with other medical providers. Emails received regarding scheduling or billing needs will be directed to contact the main office. Clinical concerns should be addressed in face-to-face sessions. Should you contact your clinician by email regarding non-emergent clinical matters, you will be scheduled with your clinician to be able to discuss these concerns face to face.

Emergency Situations

If you are in an emergency situation and cannot reach us, please contact 911 or go to the nearest emergency room. Voicemails are checked during business hours only. If there is a crisis, please call the crisis services available in your county.
Allegheny County Resolve Crisis Network: 888-796-8226
Beaver County: 724-371-8060
Butler County: 800-292-3866
Clarion County: 814-226-7223
Washington County: 877-225-3567
You may also utilize national crisis hotlines by texting TALK to 741-741 or call 1-800-273-TALK for the National Suicide Prevention Lifeline. Please notify us as soon as possible if any crises arise.

Medication

Medication refills will occur only at scheduled medication management appointments. It is ultimately your responsibility to make sure you do not run out of medication management before your next scheduled visit. If you are going to run out before then, please give the office at least 5 business days notice. Please check with your pharmacy first to ensure that you do not have any additional refills, possibly under a different prescription. We do not respond to pharmacy-generated refill requests. The frequency of medication management sessions will be determined at the time of appointment. At a minimum, you will need to be seen every 3 months. Only one emergency 30-day script will be given to you to enable you to set up your next appointment. You are responsible for all medication prescribed to you, meaning you will take medication as prescribed and agree not to sell, share, or trade medication. Doing so will result in immediate discharge from CAPS. Any controlled substances that are misplaced or stolen will not be replaced. To help prevent prescription drug abuse please be advised we do monitor all patients' controlled substances through Pennsylvania's Prescription Drug Monitoring Program. By signing these policies, you agree to not request or accept the same class of medication from any other physician/prescriber while receiving medication from CAPS.

Professional Services Outside of Session

We will try to complete all work during our scheduled sessions. It may occasionally be necessary for us to charge on a prorated basis for professional services that require extensive time commitment such as report writing, telephone conversations lasting longer than 10 minutes, and consultations with other professionals that you have requested. The charge for these services will be billed at the out-of-pocket rate listed below. This amount is not covered by insurance and cannot be billed to insurance.

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Appointment Cancellation Policy

You will receive up to two automated email message reminders, one week prior and one day prior to your scheduled appointment. If you need to cancel an appointment, please let us know as far in advance as possible by calling the main office directly. If you need to reschedule, we require at least 24 business hours' notice to avoid a charge. Appointments must be cancelled by the same hour the preceding day, and Monday appointments must be cancelled by the preceding Friday. This will allow for another family to be offered this time slot. Patients or families who do not adhere to this courtesy will be charged the full amount of the appointment missed at the self-pay rate. Late cancels or no-shows for initial appointments will not be rescheduled. These policies apply to all appointments, both in-person visits and telemedicine sessions.

Accepted Insurance Plans/Benefits

We accept Highmark, UPMC, Aetna, United, and Intergroup insurances. We do not participate in medical assistance insurances. It is your responsibility to consult your insurance provider prior to treatment to determine coverage and if a preauthorization is required prior to seeking treatment. We will do our best to help you interpret your health care benefits, however, it is ultimately your responsibility to understand which services are covered under your plan. Questions regarding coverage for treatment should be directed to your insurance provider. We will need to keep a copy of your insurance information on file. Please notify us if there are any changes to your coverage. If your insurance changes while you are receiving treatment and you acquire a balance, the balance is immediately due and payable by you.

Balances and Account Responsibilities

Any applicable payment or copay must be paid at the time of your appointment. Your copay is determined by your insurance. We accept cash, personal checks, credit card payments, or electronic funds transfer. We reserve the right to discontinue treatment for non-payment of any kind. We will gladly submit claims to your insurance carrier as a courtesy to you. We do require a valid credit card to be held on file. This card information may be stored for future financial obligations. All financial responsibilities will be charged to the card on file within 5 days of the visit. If the card on file is changed or expires a new written authorization for a new payment method will need to be provided immediately.

Termination of Treatment

You may terminate treatment at any time for any reason. We will provide referrals to other qualified providers. Rest assured we will always be looking out for your best interest and this includes referring you to the right level of care if we cannot adequately meet your needs as an outpatient facility. In the event that medical recommendations are not followed up on, or if you no-show/late cancel for three appointments, your care may need to be transferred to a provider other than CAPS. We reserve the right to discontinue services for inconsistent participation in treatment, as demonstrated by repeated cancellations. After 4 months without being seen by a CAPS provider, you will be automatically discharged from the practice. We do not specialize in the treatment of substance abuse disorders, eating disorders, or severe intellectual impairment (with a documented IQ of 70 or below). If we determine that one of these is your primary diagnosis, we will refer you to a treatment provider who specializes in this type of care.

6500 Brooktree Road Suite 208, Wexford, PA 15090
Phone: 724.799.8558 Fax: 412.430.3383

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Charge Authorization Form

Name (as it appears on Credit Card)
_____

Patients Name _____
Zip Code for Card Holder_____
Credit Card Number _____
Expiration Date _____
Three Digit Security Code on back of card _____
Is this card an FSA or HSA? Yes_____ No_____
If yes an alternate credit card is required

Alternate Card to FSA/HSA account

Name (as it appears on Credit Card)
_____

Patients Name _____
Zip Code for Card Holder_____
Credit Card Number _____
Expiration Date _____
Three Digit Security Code on back of card _____

Authorization Agreement

I agree to allow CAP Solutions to keep a valid credit card on file. This card information may be stored to pay future financial obligations. I understand that all financial responsibilities will be charged to this card with-in 5 days of the visit. If I change the credit card specified, I agree to provide written authorization for the new credit card to CAP Solutions immediately.

Card Holder Signature _____

Date _____

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Self Pay Fee for Services

Service	Psychiatrist
Initial Evaluation	$295 (if problem set is limited, may be as low as $195)
Medication Management Appointment	$150 for first 15 minutes, $50 for each additional 15 minutes

Service	Therapist
Initial Evaluation	$149
Therapy Session	$99 per hour
Face-to-face Consultation at School Site	$99 per hour

Additional Fees
(note that these fees are NOT billable to your insurance)

Self-pay rate for no-show appointment or late cancellation (less than 24 hours' notice)	Full amount of missed session ($130 for med checks, $99 for therapy)
Returned checks	$35 or amount charged by our bank
Forms (MA, FMLA, Disability, etc.)	$5 per page ($10 minimum)
Any personalized letter (IEP, 504, etc.)	$20
Referral (Family Based, Service Coordination, School Based, IOP, etc.)	$5 per page of referral packet
Fees for medical records	The per page fee is as follows: pages 1-20 $1.46 per page, pages 21-60 $1.08 per page, pages 61+ $0.36 per page.

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.
As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.
We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to an appointment.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information to our business partners for the purposes of billing and accounting.
We may contact you, by text message, by email, or in writing to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.
The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:
- Most uses and disclosure of psychotherapy notes;
- Or for Collaboration with other providers outside of our practice.

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You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI. There may be limitation to this.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket," in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.
It is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint. Feel free to contact the Practice Compliance Officer (Dan Udrea MD) for more information, in person or in writing.

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Informed Consent to Treatment

Patient Name: _____ D.O.B.:_____

I, _____ or my child_____, have/has voluntarily participated in an evaluation at Child and Adolescent Psychiatric Solutions. The diagnosis and the extent of any specific problems have been adequately explained to me. Also, I have been informed of the risks and benefits of any proposed treatment, the risks and benefits of alternative treatments, and the likely effect of no treatment.

I have read the above information and understand what treatment services will be provided. Any questions I have about the above matters have been answered by Child and Adolescent Psychiatric Solutions staff.

I voluntarily consent to receive the recommended treatment.

_____ _____

Patient (14 years and older) Date

_____ _____

Parent or Legal Guardian (if patient is a minor) Date

If the parents of a minor child are separated or divorced, the consent of both parents is required where there is a court order granting shared legal custody. It is your responsibility to confirm the legal custody status as it relates to your child. It is your responsibility to inform your Psychologist/Counselor of any shared legal custody arrangement.

For Parents who are Separated/Divorced

My signature below indicates that I have sole legal custody of my child and am not required by court order or legal arrangement to obtain the consent of any other parent or guardian prior to seeking treatment for my child.

Parent Signature _____ **Date** _____

Provider's Signature (Witness) _____ **Date** _____

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Consent to Email Correspondence

I, (patient name) _____, date of birth ____/____/____, hereby authorize Child and Adolescent Psychiatric Solutions to communicate with me via email correspondence. I understand that Child and Adolescent Psychiatric Solutions cannot guarantee the confidentiality of email correspondence due to the nature of electronic transmissions. Email should be limited to things like setting and changing appointments, billing matters, and other related issues.

Information about clinical matters should take place in person with face-to face contact since email is not a secure method of contact.

Patient Signature (14 years and older) _____ _____

Date _____

Parent/Guardian Signature _____

Date _____

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Informed Consent: In-Person Treatment in the Era of COVID-19

Thank you for your continued trust in our practice. As with the transmission of any communicable disease like a cold or the flu, you may be exposed to COVID-19, also known as "Coronavirus," at any time or in any place. Rest assured that we have and will always follow state and federal regulations and the recommended universal personal protection and disinfection protocols to limit transmission of all diseases.

Despite our careful attention to disinfection and use of personal barriers, there is still a chance that you could be exposed to an illness in our office or any public space, just as you might be at your work, grocery store, or small local family gatherings. "Social Distancing" nationwide has helped reduce the transmission of the Coronavirus. Although we have taken measures to provide CDC recommended distancing and protection in our practice, due to the nature of the therapy, a typical session lasts 53 minutes which counts as prolonged exposure. It is not possible to completely prevent the transmission of a disease at all times.

Although exposure is unlikely, do you accept the risk and consent to treatment?

Yes _____ No _____

_____
Patient (if over the age of 14) / Parent Guardian's Signature

_____
Date

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Treatment Consent for Tele-psychiatry and Tele-therapy Services

Telepsychiatry/teletherapy ("Telepsych") involves use of interactive audio and video systems for the delivery of psychiatric/psychological treatment when the patient and provider are not in the same physical location. Child and Adolescent Psychiatric Solutions (CAPS) utilizes a HIPAA compliant platform with a Business Associate Agreement (BAA). Safeguards such as encryption are in place to protect your confidentiality and guard against unauthorized access. Additionally, the laws that protect the privacy and confidentiality of your protected health information also apply to Telepsych. Despite this, the nature of distributed and electronic communication can result in an increased risk of security breaches or technical challenges. Certain conditions, including emergencies, may not be well-suited for this Telepsych. Video and audio transmission Issues can lead to delays in evaluation and treatment and may limit appropriate medical decision making. A telephone/mobile phone may be utilized to enhance the quality/security of audio information. Your provider at CAPS will not allow anyone else to hear or see any part of the session except personnel who may be present to assist with the conferencing equipment or students/trainees. You will always be informed about who is present in the office. CAPS will not engage in audio or video recording of Telepsych sessions without your written consent. Your provider at CAPS has the right to withdraw withhold his or her consent to the use of Telepsych at any time during the course of your treatment.

Patient responsibilities:

1. I have the right to withdraw or withhold my consent to the use of Telepsych at any time during the course of my treatment. I understand that my withdrawal of consent will not affect any future treatment or care.
2. I will not engage in audio or video recording of Telepsych sessions without written consent from CAPS.
3. I will inform my provider If any other person can hear or see any part of the session before the session begins.
4. I understand that I must be within the State of Pennsylvania to be eligible for Telepsych. .
5. I understand that all rules and regulations that apply to the practice of psychiatry/therapy in the State of Pennsylvania also apply to Telepsych respectively.
6. I understand that I, not a CAPS provider, am responsible for the configuration of any equipment used on my computer or device for Telepsych. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I agree to revert to a telephone session should a video connection not function properly and that I may be charged for this visit directly as insurance may not cover phone sessions.
7. I understand that all clinic policies of CAPS apply to both Telepsych and in-person visits.
8. I understand and agree to be seen face-to-face at least twice per year to maintain a therapeutic and patient/provider relationship unless my provider at CAPS indicates otherwise.
9. I understand and agree that I must establish a face-to-face clinical relationship with my proposed Telepsych provider through an initial in-person consultation prior to commencing Telepsych treatment unless my provider at CAPS indicates otherwise. In the special circumstance that my provider at CAPS would permit an initial consultation via Telepsych, I will be required to verify my identity before the consultation begins.
10. I consent to pay fees and/or to have my Insurance billed in accordance with the terms outlined in this treatment consent. I further understand that not all insurance companies approach Telepsych equally as a face-to-face encounter and agree to be responsible for charges should my insurance company not pay for the service.
11. I understand that the cancellation/no-show policy outlined in this treatment consent applies to my Telepsych visits.

I have read and understand the information provided in the Telepsych section above including the section outlining my responsibilities. This Telepsych policy has been explained to my satisfaction. I hereby give my informed consent for the use of Telepsych in my/my child's medical care and authorize CAPS to use Telepsych in the course of my/my child's diagnosis and treatment.

Patient (14 years of age or older must authorize) or Parent/Guardian authorized on patient's behalf:

Print Name: _____

Signature: _____

Date: _____

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Authorization of Payment of Benefits

I request that payment of authorized benefits be made on my behalf to Child and Adolescent Psychiatric Solutions for any service furnished to me by that provider. I understand that I am financially responsible for the payment of any deductible amount, co-insurance, co-pay, and any other balance not paid for by my insurance plan. I authorize any holder of medical information about me to release to the insurance carrier and its agents any information needed to determine these benefits or the benefits payable for related services. Authorization must be signed by the patient or by an authorized person in the case of a minor or when the patient is physically or mentally challenged.

_____ _____

Signature Date

_____

Relationship to client

Receipt of Notice of Office Policies, Financial Policies, Patient Information Guide, and Notices of Privacy Practices (HIPAA)

Patient Name _____ D.O.B._____

Please place check mark beside each item to indicate that you have reviewed and received a copy of the following.

____ Office Policies

____ Financial policies

____ Notice of Privacy practices (HIPAA)

My signature denotes that I have received the above information and have reviewed it to my satisfaction.

_____ _____

Patient (14 years or older) Date

_____ _____

Parent or Legal Guardian (if patient is a minor) Date

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Primary Care Provider Consent Form

Most health insurance companies and managed care organizations request that our office have communication with your Primary Care Physician's (PCP) office for the purposes of coordination of care and of meeting quality assurance standards. This communication typically entails diagnostic information and treatment recommendations. You have the option of refusing to provide the required consent for communication between our office and your PCP's office.
If you would like to provide consent for our office to release information to your PCP's office, please print your name, sign and date below; and please provide your PCP's name and address where indicated.

Consent granted by: _____

_____ _____
Signature Date

PCP's name and address:

_____
_____
_____
_____

If you prefer to refuse consent for our office to release information to your PCP' s office, please print your name, sign and date below:

Consent denied by: _____

_____ _____
Signature Date

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Authorization for Release of Records or Information

Please complete this authorization as it pertains to additional providers our practice may need to coordinate care with, including therapists, schools, physicians, etc.

Name(s) of facility/provider/school (with correct spelling):

	1.	2.
Phone		
Email		
Address		

PERTAINING TO:_____
(Print Client Name) (Date of Birth)

INFORMATION TO BE DISCLOSED /OBTAINED:

Only the following information: (parent/client **must indicate each item** to be released/obtained

☐ PCP Medical record	☐ Psychiatric Evaluation	☐ Juvenile Court Records	☐ D&A Attendance
☐ Medications	☐ Course of Treatment	☐ CYF Records	☐ D&A Progress
☐ Consultation	☐ Discharge Summary	☐ D&A Diagnosis	☐ D&A Prognosis
☐ Neuropsychological Test Results	☐ Individual Education Plan		

Dates of Treatment:_____

This authorization expires _____ It will automatically expire one year from the date signed.
(Date of Event)

I understand that I have the right to revoke this Authorization at any time. I may not revoke it to the extent that Child and Adolescent Psychiatric Solutions has already relied upon it. I understand that Child and Adolescent Psychiatric Solutions may not require that I sign this Authorization in order to obtain treatment. I have read this Authorization, or had it explained to me, and I understand its contents.

I, _____ hereby give permission to Child and Adolescent Psychiatric Solutions to share or receive information in accordance with the above-named providers.

_____ _____

Patient (14 years and older) Date

_____ _____

Parent or Legal Guardian (if patient is a minor) Date

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Patient Information

Name _____ Sex/Gender _____ Date of Birth _____

Address _____

Phone _____ Email _____

Parent/Guardian Information

Name _____

Address _____

Phone _____ Email _____

Name _____

Address _____

Phone _____ Email _____

Primary contact for appointment reminders, emails with links to virtual appointments, phone calls regarding scheduling, medication refills, etc.:

____ Patient _____Parent/Guardian 1 ____ Parent/Guardian 2

Insurance

Provider _____

Patient's Member ID _____

Subscriber Name _____ Subscriber Date of Birth _____

Guarantor Name _____ Guarantor Date of Birth _____

Please also include a copy of the patient's insurance card (front and back) and a copy of the guarantor's photo ID.

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Social History

Patient Name _____ Date of birth _____ Today's date _____

Please include a short synopsis of what brings you in today and when these problems started:

_____

_____

_____

Previous Psychiatric History:

- Previous Psychiatrist _____
- Previous Therapist _____
- Current Therapist _____
- Wrap around services _____
- Family based services _____
- Previous Hospitalizations _____
- Partial Hospitalizations _____
- Out of home placements _____

PCP _____

Pharmacy _____

Allergies _____

Previous Medication Trials – please list type, dosing, dates, and reason it was discontinued.

Medication: _____

Medication: _____

Medication: _____

Medical History (current problems – hospitalizations, surgeries, etc.)

_____

_____

Family history – please include medical and psychiatric, as well as history of medications

Maternal:

_____

_____

_____

Paternal:

_____

_____

_____

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Lives at home with _____
Legal Custody _____
Religion/Spirituality _____

Current grade _____ Current school _____
History of schools attended _____
IEP or 504? Any school accommodations? _____
Average GPA/school performance: _____
Have you ever had to repeat a grade? Which? _____

History of abuse or domestic violence _____ CYF involvement _____

Developmental History
How many weeks at delivery? _____

Routine prenatal care? _____

Birth weight _____

Any complications after birth? _____

On time for developmental milestones?

- walking _____
- talking _____
- toilet trained _____

Any history of accidents? Bedwetting? _____

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