STEVEN B. REBARBER, M.D., LLC

4405 East West Highway Suite # 512
Bethesda, Maryland 20814
Phone and Fax: (301) 493-6984
Cell phone: (301) 675-0693

PRACTICE GUIDELINES AND CONSENT TO TREATMENT:

If possible, please print out and read the following pages, sign on the last page, and bring them with you to our first appointment.

WELCOME

This introduction is designed to describe to you the policies and methods of my medical practice. Communication is necessary for a sound doctor/ patient relationship, so please let me know if you have any questions about this information. Also, please sign this form at the bottom, to indicate that you have read or have had explained to you this information, understand and agree to the treatment policies described.

PSYCHIATRIC SERVICES

As a child and adolescent psychiatrist, I diagnose and treat disorders of feeling, thinking and behavior, and provide medical psychotherapy. Infants, children, adolescents, adults and families are in my practice. The treatments include individual and family psychotherapy, as well as medication management when necessary. (The M.D. degree and complete training in general psychiatry are preliminary to child psychiatric training.)

OFFICE HOURS

Hours by appointment
Monday through Friday: approximately 9 a.m. to 5:00 p.m.
Weekends: Emergencies only.

If you contact me by email, please be sure to leave a clear subject in the email heading, since for security reasons I do not open emails from unknown senders.

APPOINTMENTS

I work with patients on an appointment basis; please call in advance so I can reserve a time for you. Appointments begin promptly, and in consideration of the next patient, I will need to end your appointment at its specified time.

The medical psychotherapy sessions are generally 45-50 minutes, and the medication management sessions are generally 15-30 minutes. The treatment time for each session has been reserved for you or your child. Because the time is reserved, and cannot be used for anyone else, my office policy is that missed appointments will be billed for. Appointments should be canceled at least 24 hours in advance, except in the case of serious emergencies.

CONFIDENTIALITY

In compliance with HIPAA rules, the medical records of patients are confidential. Information contained in them will not be released to insurance companies, attorneys or others without written consent from the patient and/or parents. Exceptions may occur, however, e.g., if serious harm may befall the patient or others, or if I am compelled to testify at a court hearing by a judge.

I routinely use emailing to communicate certain information and to schedule appointments. Emails are considered legal documentation and can become part of the permanent records. This form of communication is never intended as delivery of therapeutic services. Please be aware that confidential information communicated over the internet can potentially be compromised, e.g., by hackers, despite our taking numerous safeguards.

Skype and other forms of internet-based video communication are not considered to be adequately secure and confidential according to HIPPA

policy. As such, it is up to the individual's discretion to utilize such forms of communication appropriately.

When treating a child or adolescent, I keep parents informed of the general progress of treatment. Personal information given to me by the youngster is kept confidential. In cases where I believe certain information must be told to the parents, I will discuss it first with the child.

I will release patient health information for treatment, payment, or healthcare operations only after getting consent from the patient and/or parents; for disclosures other than for treatment, payment, or healthcare operations purposes, I will obtain a specific authorization for disclosure from the patient and/or parents; the patient and/or parents may request alternative means of communicating protected health information; the patient and/or parents may request restrictions on disclosures of their protected health information; and I will provide, if requested, a history of most disclosures.

In addition to traditional mail delivery, reports can be emailed as a PDF document to email addresses which you have provided. I cannot guarantee 100% privacy if you authorize reports to be disseminated in this manner.

Moreover, if at any point, you are dissatisfied with the procedures for protecting and properly disclosing information, I will be happy to discuss it with you. Please also be aware that health care providers and health plans generally cannot condition treatment on obtaining a patient's authorization for disclosure of information for non-routine uses, and that patients and/or parents are entitled to complain to a covered provider, health plan or the Secretary of Health and Human Services (HHS) about violations.

EMERGENCIES

If I am not in my office, you can reach me, or leave a message for me at (301) 675-0693 or email me at www.therapyappointment.com Please

specify if it is an emergency, and I will return your call as soon as possible. If you cannot reach me promptly during an emergency, go immediately to the emergency room of the nearest hospital and ask the physician to call me.

When I am unavailable, for example, during vacations, I routinely leave contact information for myself, or for a physician who is covering for me, on the outgoing message of my office answering machine, at (301) 493-6984.

MEDICATIONS AND PRESCRIPTIONS

Medication may be prescribed as part of the treatment, and I will explain its expected emotional and/or physical effects. Please call me if you experience any unexpected changes.

Most patients will be seen on at least a monthly basis until the appropriate medication and dosage(s) have been determined. After stabilization, patients are generally seen at least every six months. Changes of medication generally require a face-to-face appointment. A new appointment is indicated if prescriptions are running out. Please also note: stimulant medications (e.g., Ritalin, Adderall) require a written prescription and cannot be telephoned into a pharmacy.

For a refill of a prescription that requires my permission, please call your pharmacist and have them fax a refill request to (301) 493-6984. Also, please give me several days notice before the medication supply runs out, and be sure to specify if you wish a prescription to be for 90 days, instead of 30 days.

TESTS

Special tests are sometimes necessary to help diagnose psychological or learning disorders, or to help determine whether an emotional problem has physical elements or a physical cause. The use of certain medications will require laboratory monitoring. I will discuss the use of all tests with you and your child prior to my ordering tests.

PAYMENTS

Fees are generally based upon the length of time of a session. Please remember that while insurance companies may reimburse the patient for psychiatric care, payment of the bill is your responsibility. If you do have insurance, you should contact the Customer Service number on your insurance card, and ask if they reimburse for mental health coverage; if they reimburse for out-of-network providers; if pre-authorization is required, and, if so, on what terms; and what forms the physician needs to fill out in order to get pre-authorization, and where to mail or fax the forms to. It is also important to check with your insurer regarding your mental health coverage, since some psychiatric services, e.g., parent meetings without the child present or telephone sessions, are not reimbursed by certain insurance carriers.

Please make full payment at the time of each appointment. This simplifies record keeping for us both. A billing form will be given at the end of each session. In order to not use up time during the session for business matters, many of my patients find it is helpful to write out the payment before the session. When paying by check, please write down the date of service that the payment is for.

Good treatment sometimes involves services provided in addition to the regularly scheduled appointment, examples of which include telephone calls with patients, parents, school personnel, collaborating therapists, etc.; consulting with teachers and school officials; and providing written statements for others. I will generally bill for any such professional service based on the time involved. Please be aware that insurance companies may refuse payment for these kinds of services. I will be happy to answer your questions about fees, or discuss any problems you may have in meeting your regular payments.

INSURANCE

You will need to submit your own claims for insurance benefits. A copy of your bill and your insurance claim form should be sufficient to submit

directly to your insurance company for payment. If you require additional documentation, I will be glad to provide it, but please keep in mind that I cannot accept responsibility for collecting your insurance claim or for negotiating a settlement on a disputed claim.

COMPLETING TREATMENT

At the end of the course of treatment, one or more sessions are held to review the progress made, clarify any issues that might need addressing in the future, and formally end the treatment. Such sessions are an important part of the therapy.

If, at any point, you are not satisfied with the treatment being provided, and wish to end the treatment before the standard course of treatment is completed, please notify me of your decision. Furthermore, I am always available to discuss treatment alternatives, including referral to other therapists, to be sure that you receive the treatment you desire and need.

After ending treatment, if at any point you wish to consider re-entering treatment, please feel free to contact me.

THANK YOU FOR ENTRUSTING ME WITH YOU OR YOUR CHILD'S MEDICAL TREATMENT. I WILL DO EVERYTHING POSSIBLE TO KEEP THAT TRUST.

STEVEN B. REBARBER, M.D., LLC
Maryland Medical License # D40396
Board Certified in Child and Adolescent Psychiatry, and General Psychiatry

I have read and understand the above practice guidelines, including the practice's compliance with HIPAA rules:

Name (please print): _____
Name of patient (if applicable):_____

Signature of patient, parent or guardian:
_____ Date: _____

Emergency Contact:
Name: _____
Relationship to patient: _____
Address and Phone Number:

_____

_____

Primary Care Physician/Pediatrician:
Name: _____

Phone Number: _____