FLOWER CITY PSYCHIATRY
(585) 445 8789
THE PARK AT ALLENS CREEK
140 Allens Creek, Suite 200
Rochester, NY 14618

POLICIES AND PROCEDURES

Client Contract
Please take the time to carefully read this contract in its entirety. This contract sets forth the office policies of Flower City Psychiatry PLLC/Allison L Giordano, M.D. and contains many elements important to your care. Please ask us if you have any questions. We take your care very seriously and we want to make sure you agree to all of our policies before you become a client.

Consent for Treatment
I, the undersigned patient or legal guardian, consent to evaluation and medically necessary interventions by Flower City Psychiatry P LLC/Allison L Giordano, M.D. . I understand that I have the right to be informed of and participate in the selection of treatment modalities. I understand I can terminate consent for treatment at any time and that Flower City Psychiatry PLLC/Allison L Giordano, M.D. may terminate consent for treatment at any time. Potential reasons include but are not limited to misusing psychiatric medications or misusing psychiatric services. If this should occur, Flower City Psychiatry PLLC/Allison L Giordano, M.D. will discuss the reasons with me and will provide me with one or more referrals for another treatment provider.

Notice of Privacy
As required by law and professional ethics, we keep all client personal information in strict confidence, except as defined within this contract. I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Confidentiality
There are limits to confidentiality as required by law. Confidentiality cannot be maintained when:

- A patient is in imminent danger of hurting themselves or another party
- There is suspicion of child or elderly abuse, neglect, or sexual molestation
- Assessment of mental competence in a legal proceeding
- The doctor/patient privilege is used to shield the planning of a crime or tort.

If our office is required to release information through subpoena, court order, or other action of law, then we will abide by the law and release the required information as directed.
While an appointment is in session, confidentiality does not apply to all participants in the session. If you are not comfortable releasing your personal information to an appointment participant, then you must require that the participant leave the appointment while it is in session. Flower City Psychiatry PLLC/Allison L Giordano, M.D. accepts no liability whatsoever for release of personal information to appointment participants.
<u>Adolescent Confidentiality:</u>
Adolescents possess some unique rights as it pertains to confidentiality, specifically regarding pregnancy status, status of some sexually transmitted diseases, substance use, and use of oral contraceptives.

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Release of Information
Upon your request and completion of our authorization form, Flower City Psychiatry PLLC/Allison L Giordano, M.D. will release your personal information to third parties as directed by you. This can be useful to involve other parties in your care, such as family members, schools, and/or professionals.

In the event of an emergency, Flower City Psychiatry PLLC/Allison L Giordano, M.D. may use her professional judgment to release your personal information as she feels is appropriate to respond to the emergency. In addition to your emergency contact, the authorities may be notified if Flower City Psychiatry PLLC/Allison L Giordano, M.D. becomes concerned about your personal safety or the safety of someone else.

Availability
Our services are provided by appointment only and walk-ins are not accepted; however, there might be instances in which you might call and an appointment will be available on the same day. You may call our office at (585) 445-8789 for any questions or concerns.

Non-urgent and Emergency Contact
I agree to call Flower City Psychiatry PLLC/Allison L Giordano, M.D. for any non-urgent medical or psychiatric issues, including side effects to medications. Dr. Allison L Giordano might not always be available to answer the phone when you call, but will make every effort to return your call within 2 business days. In the event of an urgent situation in which you cannot wait for a return call or in an emergency, I agree to immediately call 911 or go to the nearest emergency room. Please do contact her after you have received proper emergency assistance so that she can be aware of the situation.

Fee Schedule

Price	Appointment Type	Approx. Duration
$400	Initial Consultation	60 minutes
$300	Secondary Consultation	60 minutes
Varies	Follow-up Therapy +/- Medication Management	45 minutes

In some cases, it will be more effective to have two separate consultation sessions lasting 60 minutes each: one as a guardian/caretaker interview and the other to evaluate the child/adolescent. This can be discussed further with Flower City Psychiatry PLLC/Allison L Giordano, M.D. during the appointment scheduling process. Fees will vary from what is listed above and will be discussed prior to setting up the appointment.

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Initial Consultation: I understand that the initial encounter with Flower City Psychiatry PLLC/Allison L Giordano, M.D. is a consultation. At the end of the evaluation process, I will be provided with a working diagnosis and treatment recommendations which might include services that Flower City Psychiatry PLLC/Allison L Giordano, M.D. is unable to provide. For example, if the patient requires a higher level of care based on the current acuity level. Additionally, Flower City Psychiatry PLLC/Allison L Giordano, M.D. might require collateral information from other parties (i.e. schools, other treatment providers) prior to being able to provide treatment recommendations. I understand that by completing the evaluation process it does not mean that Flower City Psychiatry PLLC/Allison L Giordano, M.D. has assumed responsibility for my care. This will be determined by Flower City Psychiatry PLLC/Allison L Giordano, M.D. based on the treatment recommendations.

Payment

I understand that I am responsible for payment in full at the time services are provided. Fees for service will be discussed in advance between myself and Flower City Psychiatry LC/Allison L Giordano, M.D. and any changes to the fee schedule will be made known to me.

I agree to complete the Credit Card Payment Authorization Form prior to my first consultation. I understand that my credit card will not be charged until the time of service unless I cancel my appointment within 24 hours of the scheduled appointment time. My credit card will also be charged if I fail to show up for my appointment. Failure to pay the agreed amount at the expected time may result in transfer of care.

Payment for all services not covered by your insurance is expected at the time of your appointment unless other arrangements are made. You will also be responsible for any payment for any services requested and/or approved by you, but not covered by your insurance carrier. In addition you will be responsible for any services rendered to your children for services requiring interpretation by an outside agency and billed by them directly, such as labs or EKGs. It is a responsibility of patients/parents/guardians to know what is covered and not covered by their insurance carrier. If we do not participate with your insurance, full payment is expected on the date of service. We will provide sufficient documentation for you to submit a claim to your insurance company for your visit, and reimbursement should be sent directly from them to you. For your convenience, payments to the Flower City Psychiatry may be made by cash, check or credit card. I agree to make payments at the time of checkout as detailed above.

In the event the bank returns a check to Flower City Psychiatry, I agree to pay a service charge of $30 in addition to any bank fee.

I understand there are additional services that may require billing as well. These include but are not limited to: reading and writing of reports, obtaining collateral information from other providers, phone calls lasting longer than 15 minutes in duration, and frequent phone calls. Flower City Psychiatry PLLC/Allison L Giordano, M.D. reserves the right to charge for these services at a prorated fee of $400/hour, or to require me to schedule an office appointment to address these services. Flower City Psychiatry PLLC/Allison L Giordano, M.D. will not split the bill between two guardians nor try to collect from a guardian who does not come to the sessions. The responsibility for payment or to recover what is owed is on the guardian who brings the child to

the appointment. If payment for services is not paid within 30 days from when the service was provided, there may be a $50 late fee added to the amount due with an additional $50 for every month thereafter that the payment continues to be late.

Financial hardship should never medical care. Since open communication can benefit both parties, any hardship should be discussed with Flower City Psychiatry PLLC/Allison L Giordano, M.D. earlier rather than later, to simplify what can be a difficult situation. Please feel free to speak with our staff members if you have any questions about our policy. Payment plans can be created upon request.

Cancellation Policy
Appointment times are reserved just for you. Flower City Psychiatry PLLC/Allison L Giordano, M.D. is happy to change or cancel your appointment, but she does require notice at least 24 hours (1 business day) in advance. If a cancellation is not made within that time, or if the appointment is missed without notification, Flower City Psychiatry PLLC/Allison L Giordano, M.D.reserves the right to charge me the full fee for this appointment. Emergencies will be taken into consideration. If the appointment is paid in advance and cancel the appointment before the required 24 hours (1 business day), then a full refund will be offered. I understand that in the event of a missed or cancelled appointment, medications may or may not be refilled depending on the level of clinical supervision required for the medication.

Late Arrival
If I am late to my appointment, I understand that Dr. Allison L Giordano may not be able to see me, or may only be able to see me for the remainder of my appointment time in consideration of other patients.

Electronic Communication
I understand that voicemail, text, and e-mail are not confidential means of communication with Flower City Psychiatry PLLC/Allison L Giordano, M.D. . I will reserve their use for managing appointments or for requesting direct (in-person, phone, or videochat) communication. I will allow Flower City Psychiatry PLLC/Allison L Giordano, M.D. to leave messages on my voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality.

Health Insurance Coverage
I understand that Flower City Psychiatry PLLC/Allison L Giordano, M.D. does not participate in any health insurance plans **EXCEPT: Excellus Blue Cross Blue Shield and Aetna**. I may be able to submit insurance claims for reimbursement as out-of-network benefits; however, it is solely my responsibility to seek reimbursement, verify coverage, and submit claims. Flower City Psychiatry PLLC/Allison L Giordano, M.D. might be able to provide me with a form that I can submit on my own to the insurance company and it is my responsibility to find out if this is possible. Flower City Psychiatry PLLC/Allison L Giordano, M.D. accepts no responsibility for lack of payment from insurance companies.

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Discharge

Discharge is the formal release of a professional from their obligation and care to a client. Discharge can occur for many different reasons, some which are as simple as a client moving out of the area or getting so much better that regular care is no longer required. Discharge also occurs if our office is unable to communicate or schedule an appointment with me for a 6 month period of time.

Termination of Care

Flower City Psychiatry PLLC/Allison L Giordano, M.D. will not begin care, or will not continue care, if in her professional opinion she can no longer be of benefit to me and she will discuss this with me. I will be provided with one or more referrals for continuation of treatment, and I will be discharged if appropriate. I have the right to terminate treatment at any time.

By signing, you certify that you have read, understand, and agree to all of the policies in this contract.

Patient Name: _____ Date of Birth: _____

Patient signature: _____ Date: _____

Name of Legal Guardian (if applicable): _____ Relation: _____

Signature of Legal Guardian (if applicable):_____ Date: _____