
Doucette Consultants UPDATED Initial Patient Packet w/ Consent to Telepsych Treatment:


**NOTICE of PRIVACY PRACTICES ACKNOWLEDGEMENT FORM**

CLIENT STATEMENT: I have been provided with and read a copy of the Notice of Privacy Practices of this clinic.

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**PATIENT SIGNATURE or PERSONAL REPRESENTATIVE** **DATE**

_____ _____

**PRINT PATIENT NAME or PERSONAL REPRESENTATIVE** **Description of Personal Representative's Authority**

**AUTHORIZATION for USE or DISCLOSURE of PROTECTED HEALTH INFORMATION**

I authorize my clinician and/or administrative staff to disclose general medical information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of this clinic.

**NAME and RELATIONSHIP of person(s) you wish to allow access – for example, your spouse, child, sibling, neighbor, caretaker, clergy, or close friend:**

| NAME OF PERSON | ENTITY RELATIONSHIP | CONTACT NUMBER |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me, or, if the purpose of the disclosure is related to research, at the end of the research study.

I understand that the information used or disclosed pursuant to this authorization may be disclosed by my clinician and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to my clinician. I understand that a revocation is not effective to the extent that my clinician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Regardless of whether you provide us with this authorization, services and billing/payment operations will be conducted. However, if your treatment is for any of the following purposes, we have the right not to provide you with medical services:

1) If your treatment is related to research

2) If health care services are provided to you solely for the purpose of creating protected health information for disclosure to a third party

**CLIENT STATEMENT: I have read and fully understand and agree with the above policy and conditions.**

_____ _____

PATIENT SIGNATURE or PERSONAL REPRESENTATIVE DATE

## Clinic Policy and Procedures

**Appointments:** To schedule an appointment, please call or text (504) 333-4943, and a treatment team member will help assist scheduling an appointment. You can also send an email request to nurse@drdoucette.com. A courtesy appointment reminder will be provided 24hour prior to your appointment.

**Payment policy:** At present, Dr. Doucette via Doucette Consultants LLC. does not accept private insurance, Medicare, or Medicaid. Please contact your insurance carrier about out-of-network benefits, co-payments, and reimbursements. Dr. Doucette will give you a superbill, or medical receipt for insurance reimbursement, at your request. Please note this information will contain personal and confidential data necessary for billing insurance companies including Date of service, your full name, date of birth, name of diagnosis and diagnostic ICD code and, type and length of service provided using CPT codes.

**Treatment fee and payment policy:** A fee will be charged to schedule all visits. Payment in full is required 24 hours prior to the date of service. An invoice will be sent via email using PayPal (accepts all major debit and credit cards), or electronically with Venmo (@doucettepsycNOLA). The payment fee schedule is as of follows:

| | |
|---|---|
| **- Initial Adult Psychiatric Evaluation** | **$250** |
| **- Adult Follow-up medication management (15mins)** | **$150** |
| **- Adult Follow-up medication management and psychotherapy (25 mins)** | **$200** |
| **- Adult Follow-up medication management and psychotherapy (50 mins)** | **$250** |

**No-show policy:** A scheduled appointment means a specific time is allotted for each client. If you are unable to make your appointment, or need to re-schedule, please contact our office via email or text "Need to cancel appointment" to (504) 333-4943 at least 24-business hours prior to your scheduled appointment time to avoid a no-show fee. If you cancel/request to reschedule less than 24-business hours prior to your scheduled appointment, you will be charged in full, and the balance will need to be paid in full prior to scheduling the next appointment.

**Medication refill policy:** All medication requests should be discussed during your medical visit. If you do require medication refills outside of your scheduled appointment time, please allow up to 72 hours for confirmation of refill request. A fee of $25 will be charged for all non-controlled substances, and $35 for all controlled substance requests.

**Duty to warn:** In the cases in which the client discloses or implies a plan for suicide, the provider is required to make all attempts to notify legal authors if necessary. When a client discloses intention or a plan to harm another person, the provider is required to notify the intended victim and report this information to legal authorities. If the client states or suggests they are abusing a child or vulnerable adult, the provider is required to report this information to the appropriate social service agency and/or legal authorities.

**Authorization to release information:**

I hereby authorize Ashley P. Doucette, MD/MPH to release all or part of my record (including alcohol or substance abuse, if applicable) to insurance company, health care plan administrator, worker's compensation carrier, welfare agencies, or their intermediaries or carriers, or any other person or corporation which is or may be liable under contract or assignment of benefits to Ashley P. Doucette, MD/MPH for all or any part of my charges. I understand that this clinic may be required to provide a report of the initial evaluation or consultation to my referring physician with my written consent.

**CLIENT STATEMENT:** I have read and fully understand and agree with the above policy and conditions.

_____ _____

PATIENT SIGNATURE or PERSONAL REPRESENTATIVE DATE

DOUCETTE
CONSULTANTS

## Patient Information and Consent for Telepsychiatry

### Introduction

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the physician (provider) and the patient are not in the same physical location. The interactive electronic systems used in tele psychiatry incorporate network and software security protocols (encryptions) 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 of telepsychiatry: Telepsychiatry, as with any medical procedure, may have potential risks associated with use, including but not limited to:

- Information transmitted may not be sufficient to allow for appropriate medical decision making by the provider.
- Provider may not be able to provide medical treatment using electronic equipment, nor provide for an array of emergency care
- Delay in medical evaluation and treatment due to failure of equipment
- Security protocols can fail, although extremely unlikely, causing breach of privacy in confidential information
- Lack of access to all the information that might be available in a face-to-face visit, which may result in medical judgment.

### Alternatives to Telepsychiatry:

- Traditional face to face visit, as per request, and as schedule permits for provider.
- **The use of telemedicine will be encouraged due to Covid pandemic.**

### Client responsibilities with use of telepsychiatry:

Client responsibilities using telepsychiatry include the following:

1. I will not record any telepsychiatry or treatment communication sessions without written consent by the provider.
2. I will inform the provider if any person can hear or see any part of the session before it begins.
3. I understand that third parties may be required to join for technical support. I may decline this interaction. If I decline this request and equipment is unusable, I may forfeit my option to use telepsychiatry.
4. I understand that I, nor the provider, am responsible for the configuration of computer equipment on the client's computer, and it is the responsibility of the client to ensure their functioning.
5. I understand I must be a resident of the state of Louisiana to be eligible for telepsychiatry treatment services from this provider, including prescription medication.

**Client consent to the use of telepsychiatry:** I have read and understand the information provided above regarding telepsychiatry. I have discussed the above information, and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry for my medical care and authorize Dr. Doucette to use telemedicine during my diagnosis and treatment.

_____ _____

PATIENT SIGNATURE or PERSONAL REPRESENTATIVE DATE