MelrosePsych

8060 Melrose Avenue, Ste 200 | Los Angeles, CA 90046 | 323.391.4830 | drjay@melrosepsych.com
1455 NW Leary Way, Ste 400 | Seattle, WA 98107

Dr. Gerald "Jay" M. Baltz, DNP, PMHNP-BC

MelrosePsych Initial Appointment Packet

PATIENT INFORMATION AND FEES AGREEMENT

Last Name: _____ First Name: _____ MI: ___ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Best phone number to reach you: _____

Email: _____ Occupation: _____

Gender: _____ Height: _____ Weight: _____ Age:_____

Marital status: _____

Primary Care Provider: _____ Phone: _____

Prior Psychiatric Provider/Therapist : _____Phone:_____

Who can we thank for referring you? _____

In emergency notify: _____ Phone: _____

FEE SCHEDULE

Initial Psychiatric Evaluation: **$300**
Lost Rx/Rx between appointments: **$40**
Forms between appointments: **$60**

Follow-up Medication Management: **$150**
Missed appointment fee: **Full session fee**
Emotional support animal letter: **$60**

Print Name: _____ Signature: _____ Date: _____

AGREEMENT FOR ALL PATIENTS

- I have read, understand, and consent to the terms in this agreement. I give my informed consent to receive psychiatric services from Dr. Gerald M. Baltz, DNP, PMHNP-BC.
- I have read, understand, and consent to the fees in this agreement.
- I agree to the secure storage of my credit or debit card number, expiration date, security code, and billing ZIP code until I remove it or request it be removed.
- I agree that fee is due at the time of service, and that I must pay my balance before beginning each session. I can pay with Apple Pay, Android Pay, credit card, debit card, or cash (in person).
- I agree and approve that my credit/debit card kept on file be charged to pay for all services, including but not limited to missed appointments, balances, lost prescriptions, forms, or prescriptions requested between appointments.
- I understand that Dr. Gerald M. Baltz, DNP, PMHNP-BC is not a member of any insurance panels but may be treated as an out-of-network provider. I will contact my insurance carrier for more information. All care is provided on a fee-for-service basis.
- I understand that fees are reviewed annually, but may change at any time with four (4) weeks notice via email

Please Initial: _____ Date _____

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OFFICE POLICIES & TREATMENT AGREEMENT FOR PSYCHOTHERAPY AND MEDICATION MANAGEMENT SERVICES

This form provides you (Client) with detailed information regarding MelrosePsych office policies and services. Below, 'Patient', 'Client', 'You' and 'Yours' are used interchangeably.

FEES:
Session fees are subject to an annual review and will be discussed with client in advance of any increase. Your fee has been set at the below amount per session.

Fee for service: **Initial:** $300 **Follow-Up:** $150 **Missed Appointment:** Full session fee

PAYMENT POLICY:
You must pay your balance in full each time you are seen. Payment must be by cash, credit card, debit card, Apple Pay, or Android Pay. We require an active/valid credit card to be on file at all times. You agree to the secure storage of your card number, expiration date, and security code. You approve the use of your card to pay for all services, including missed appointments, balances, lost prescriptions, or prescriptions requested between appointments. MelrosePsych does not take personal checks. Failure to pay your account balance may result in suspension of your treatment until any balance due is paid.

PUNCTUALITY:
You understand that when you book a time slot, that time slot is entirely for you and another patient cannot be seen. You agree that it is your responsibility to come on time to all appointments and that part of the therapeutic process is taking responsibility for your care. If you are more than 10 minutes late to an appointment, you may not be seen and may be charged the standard fee for missed appointments. **Persistent tardiness or missed appointments may result in termination of care.**

CANCELLATION:
Since scheduling of an appointment involves the reservation of time specifically for you, **a minimum of 48 hours (2 days) notice is required for re-scheduling or canceling an appointment. Unless we reach a different agreement, the full fee will be charged for sessions missed without such notification to the card on file. Sessions confirmed via voice or text message are considered confirmed.** Most insurance companies do not reimburse for missed sessions. In the event of an emergency late cancel, we will do our best to reschedule within the same week, but cannot guarantee an available appointment.

Gerald "Jay" Baltz, DNP is considered an out-of-network provider for insurance providers. Upon your request, Dr. Baltz can supply you with a superbill to submit to your insurance company for reimbursement if you have out-of-network benefits. Please check with your insurance carrier.

PHONE SESSIONS:

It is our office policy to conduct face-to-face or tele-psychiatry sessions, due to the clinical benefits to your therapy and medical assessment. However, there are instances where phone call appointments may be necessary. Please make arrangements with your Provider more than 24-hours in advance if you need a phone session.

ELECTRONIC COMMUNICATIONS/TELEPSYCHIATRY/ELECTRONIC PRESCRIBING:
We offer telepsychiatry using a secure, HIPAA compliant, dedicated telemedicine platform called Sessions, by Psychology Today. During the COVID19 national health emergency, both new and current patients may take advantage of virtual appointments. You will need to have access to this platform in order for us to treat you. Many patients use a laptop or tablet equipped with a microphone and camera, if they have it available. If not, they may use a smartphone like an iPhone or Android phone.

During the course of treatment, Dr. Baltz may prescribe you medications, using a secure, HIPAA compliant electronic prescribing program. For Dr. Baltz to treat you or prescribe you medication, you must be a resident of Washington or California. All sessions must be performed with you at your home address or at a different verifiable address so that we know where you are located in case of an emergency. Turnaround time for all electronic communications is generally 24 hours during business days.

CONFIDENTIALITY:
All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your (Client's) written permission, except where disclosure is required by law.

- **When Disclosure IS Required by Law**: Some of the circumstances where disclosure is required by the law are: where there is a reasonable suspicion of child, dependent or elder, abuse or neglect; and where a client presents a danger to self, to others, to property, to provider, or is gravely disabled.
- **When Disclosure MAY be Required by Law**: Disclosure may be required pursuant to legal proceedings. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy or medical records and/or testimony by the custodian of the records. In couples and family therapy, or when different family members are seen individually, confidentiality and privilege do not apply between the couple or among family members. Provider will not release records to any outside party unless authorized by all family members who were part of the treatment.

CONFIDENTIALITY RISKS FOR E-MAILS, CELL PHONES, COMPUTERS AND FAXES:
It is very important to be aware that computers, email, and cell phone communication can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, in particular, are vulnerable to such unauthorized access due to the fact that servers have unlimited and direct access to all emails that go through them. Providers' emails and data on their computer-like devices are password protected and not encrypted. Despite protective efforts, sometimes laptops or computer-like devices (such as iPad/smart phones) may be stolen. When faxing, there is a possibility that faxes can be sent erroneously to the wrong address and computers. Please notify your Provider if you decide to avoid or limit, in any way, the use of emails, cell phones or faxes, or storage of confidential information on computers. If you communicate confidential or private information via email or text, your Provider will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted, and s/he will honor your desire to communicate on such matters via email. Please do not use email or faxes for emergencies. **Please do not text private or important information at any time.**

SELF-HARM:

If there is an emergency during our work when your Provider becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychological or psychiatric care, they will do whatever they can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive proper medical care. For this purpose, the law permits the Provider to contact the person whose name you have provided on the intake form as the emergency contact, without your verbal or written consent.

HEALTH INSURANCE & CONFIDENTIALITY OF RECORDS:
Health insurance carriers or HMO/PPO/MCO/EAP cannot require disclosure of your confidential information because Dr. Baltz does not participate with any insurance panels. He is able to provide you a superbill upon request, but is not able to provide records to health insurance companies regarding reimbursement. Regarding other requests, unless authorized by you explicitly, the Psychotherapy Notes will not be disclosed to any insurance carrier. You understand that your Provider has no control or knowledge over what insurance companies do with the information submitted or who has access to this information. You must be aware that submitting a mental health invoice for reimbursement carries a certain amount of risk to confidentiality, privacy, or to future eligibility to obtain health or life insurance will honor your desire to communicate on such matters via email. Please do not use email or faxes for emergencies.

LITIGATION LIMITATION:
Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc.), neither you (client) nor your attorney, nor anyone else acting on your behalf will call on your Provider to testify in court or at any other proceeding.

TELEPHONE & EMERGENCY PROCEDURES:
Provider is not an emergency provider. If you need to contact Provider between sessions, please leave a message at (323) 391-4830. Your call will be returned as soon as possible. Provider will return calls within 24 hours during weekdays (Monday-Friday). Provider is not available between 10 p.m. and 8 a.m. If an urgent situation arises, please indicate it clearly in your message and Provider will return the call as soon as possible. If you are having a medical emergency, or believe yourself to be in an emergency situation, call 911, contact the National Suicide Prevention Lifelines at 1-800-273-8255, or go to the nearest emergency room.

MEDIATION & ARBITRATION:
All disputes arising out of or in relation to this agreement to provide psychotherapy and medication management services shall first be referred to mediation, before, and as a precondition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of Provider and you. The cost of such mediation, if any, shall be split equally, unless otherwise agreed. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Los Angeles County, California in accordance with the rules of the American Arbitration Association which are in effect at the time the demand for arbitration is filed. Notwithstanding the foregoing, in the event that your account is overdue (unpaid) and there is no agreement on a payment plan, Provider can use legal means (court, collection agency, etc.) to obtain payment. The prevailing party in arbitration or collection proceedings shall be entitled to recover a reasonable sum for attorneys' fees. In the case of arbitration, the arbitrator will determine that sum.

Please Initial: _____ Date _____

MEDICATIONS:
You understand that Provider does not provide refills for controlled medications before they are due except in certain unforeseen or extreme circumstances.

You understand that Provider may require a police report if a controlled medication is reported lost or stolen and may charge a fee to replace your medication.

You agree to guard your medications carefully, and to store them in a secure place away from access by children. If you are taking a medication that creates dependence, you understand that if you lose your medication you may go into withdrawal. Provider may provide comfort medications for you to help sustain you until your next appointment.

Provider will provide you prescriptions for controlled medications to last until your next appointment and will avoid giving refills for controlled medications between appointments.

If Provider needs to give you prescriptions between appointments, a fee may apply. If you are abusing alcohol or illicit drugs, misusing prescriptions, or exhibiting behaviors which may jeopardize your safety, Provider may not continue to prescribe controlled medication to you.

You agree to take your medications exactly as prescribed and not make any changes without consulting Provider. You agree to not give away, sell, or take anyone else's medications. You agree to let Provider know what other medications you are taking from other prescribers at all times.

If you are taking a sedating medication, such as a benzodiazepine or sedative, you understand that mixing these medications with other sedatives, such as other benzodiazepines, barbiturates, alcohol, buprenorphine, or other drugs can be dangerous. You also understand that many deaths have been reported, for example, among individuals mixing buprenorphine with benzodiazepines or benzodiazepines with sedatives or alcohol.

AUTHORIZATION, ACKNOWLEDGEMENT, AND RELEASE:
With your signature below, you authorize and signify the following:

- You have read, understand and consent to the policies in this treatment agreement.
- You authorize the release of any medical information necessary to process insurance claims and give consent for your provider to speak with your therapists, doctors or caregivers while you are under my care.
- You authorize payment directly to your provider for services rendered including to your credit or debit card which you agree may be kept on file by Dr. Gerald M. Baltz, DNP, PMHNP-BC of MelrosePsych.
- You consent to receive services from your provider under the policies in this treatment agreement.
- You agree that prices for services may change at any time, and that you will be notified in writing, either through postal mail or email, with four weeks notice, before any such change takes effect.

Signature : _____

Print Name : _____

Date : _____

Please Initial: _____ Date _____