Chicago Child Psychiatry Associates
Amer Smajkic M.D.
233 E. Erie # 802
Chicago, Illinois 60610
Phone: 312-893-5701
Fax: 312-268-5085 E-mail:
asmajkic@pauboxmail.com

Treatment Agreement

Once you have arrived at an appointment with us your next decision involves the question of fit: does the kind of service we offer and the climate of my practice or my personal way of engagement fit with you well enough to warrant a try at establishing an ongoing working relationship?

This document is a brief orientation to my thinking about my psychiatric practice. After reading through it you may have questions for us. Please fax all the signed documents to 312.268.5085 or if you prefer you can email them as scanned attachment to asmajkic@pauboxmail.com . An understanding of these issues is very important. We have tried to spell out as clearly as possible how we think about these basic aspects of our practice.

Our training and experience is in providing careful child, adolescent and adult psychiatric evaluations and offering ideas for addressing the results of the evaluation. The treatment modalities at our disposal are individual psychotherapy, cognitive behavior therapy, use of psychiatric medication and supportive therapy with coaching.

Doctor patient relationship will begin on the end of the first visit once after we mutually decide that we can work together and after we agree to proposed treatment plan.

Our charges are explained in detail in the Amer Smajkic MD Psychiatric Charges document.

Payment is expected at the time of services rendered until we arrive at a different, mutually agreeable arrangement. Payment method options are cash, check or credit card.

At present time we do accept Blue Cross Blue Shield PPO insurance panel. We are not a member of any other networks. Should you choose to make use of medical insurance reimbursement benefits all the information needed for the processing of the claim is integrated into the patient account activity statement generated at the end of each month. It is important to know that once you release such sensitive personal information to unknown parties you lose control over its use. There have been instances of people being denied life or disability insurance policies based on particular diagnoses being a part of the public information domain.

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Once an appointment is set it claims that part of my day. The implicit assumption is that we will reserve that time for you only. We will not "double book" our time allotments nor we will allow a higher bidder" to replace your appointment. It follows that you will pay for a previously scheduled session whether you choose the time or not.

We practice strict, yet not absolute, confidentiality. With your permission we may respond to requests· for information regarding your treatment. Often times, especially in the treatment of dependent children, active communication with other family members is a very important aspect of the treatment process. In some rare instances in which we have reason to think that some party is in danger we are obligated, by law, to report that concern to the appropriate authority and to do our best to ensure people's safety. Otherwise we hold to the principle that what goes on in our meetings is completely confidential.

We check our confidential, secured HIIPA compliant email daily. We do our best to respond to emails especially regarding urgent matters, on the same day that we receive the message. One of our practice goals is to have good communications with patients and their families and be available as much as possible. Instructions for contacting us via email or our cell phones are a part of our routine please be aware that email is preferred way of communication. For that purpose, we would like to inform you that our email is encrypted and secure. We would also like to ask you to agree to such communications by signing this document.

We will tell you as far in advance as possible of planned absences. During times in which we are not available by telephone, an arrangement will be made with a member of our practice, trusted colleagues of comparable training and experience who may be called for emergencies. Their names and telephone numbers will be provided as the need arises.

Your signature below attests to your having read this document and that you understand its contents.

Signature:_____ Date: _____

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New Patient Registration Form

Name of the patient:_____

First Last

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender:_____ Social Security#: _____

Home Phone: _____ Cell Phone: _____

Primary Insurance: _BCBS PPO_____ Member ID #: _____Group Number:_____

Name of the Policy Holder: _____DOB of the Policy Holder:_____

Relationship to the insurer Self_____ Spouse_____ Child_____Other_____

Responsible Party. Fill out only if the insured party is a different person than the patient. Who is responsible for this service, if other than patient? (Parent, Guardian, Attorney, etc)

Name: _____Sex_____

Adress_____

Home Phone_____Work Phone _____Birth Date _____

Employer _____Social Security _____

Address _____

Consent, Assignment and Release: I hereby consent to treatment. I hereby assign my insurance benefits to be paid directly to the above provider. I am financially responsible for all non-covered or not paid services and by signing below I agree to be fully responsible for all not covered or not paid fees including collection cost if my account is sent to collections. I do understand that assignment of benefits does not release the undersigned from responsibility of payment. I authorize this provider to release any information required to process the claim. This authorization and consent shell remain in effect until such time is revoked by me. **Your insurance policy is a contract between you and your health insurance company or employer. It is your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals, precertifications, preauthorizations and limits on charges or deductibles regardless of whether or not our physicians participate. If problems arise we will attempt to work with your insurance company to help resolve the issues prior to making it your responsibility. However, please be advised that you are nevertheless ultimately financially responsible for payment should your insurance deny charges for all services rendered.**

Patient/Parent/Guardian
Signature_____ **Date_____**

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OFFICE CREDIT CARD POLICY

At Chicago Child Psychiatry Associates, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.

Without this authorization, if payment is not received within 90 days of the first statement being sent your account will be subject to collection action and we may have to decide to terminate patient doctor relationship because of unpaid service.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. The balance that is due will be processed only in if you are 30 days or more late with your payment.

I authorize Chicago Child Psychiatry Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card: ☐Visa ☐Mastercard ☐Discover or ☐ American Express.

Credit Card Number _____

Expiration Date _____ / _____ / _____ CSC security # : _____

Cardholder Name _____

Signature _____ Billing

Address _____

City _____ State_____ Zip _____

I (we), the undersigned, authorize and request Amer Smajkic MD LTD to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility. This authorization relates to all payments not covered by my insurance company for services provided to me by Chicago Child Psychiatry Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60-day notification to Amer Smajkic MD LTD in writing and the account must be in good standing. I also understand that my account may be subject to collection action if multiple attempts are made to process a payment for my balance due and that collection fees are my responsibility. Once the account is in collection if legal action was taken against provider or to receive payment from a patient all legal fees ,including attorney's fees and court costs shell be paid by the patient or guardian.

Patient Name (Print): _____

Patient Signature: _____

Date: _____ / _____ / _____

I, _____ have been given an office financial policy form and have read and agree to provide my credit card information to process any patient responsibility after claims finalize with my insurance carrier.

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Consent for Release of Confidential Information

I, _____ authorize

(Name of patient or Name of parent or guardian id applicable)

(Name of previous or current provider to obtain disclosure including fax or emaai)

_____

Name of person or organization to which disclosure is to be:

AMER SMAJKIC M.D. at 233 E. Erie # 802, Chicago IL 60611

Following information:

Collateral Information regarding my previous Psychiatric or psychological treatment

(Nature of the information, as limited as possible). Old medical records the purpose of the disclosure authorized herein is to: Coordination or care, providing collateral information (Purpose of disclosure as specific as possible).

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

(Specification of the date, event, or condition upon which this consent expires)

Dated_____ Signature of participant_____

(Signature of parent, guardian, or authorized representative when required)" "Consent for Release of Confidential Information

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Telehealth Services Informed Consent

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.
2. My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access and technical difficulties. I understand my health care provider or I can discontinue the videoconference consult/visit if it is believed videoconferencing technologies are not adequate for the situation.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that no results for anticipated can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Individuals others than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
    - ask non-medical personnel to leave the telehealth examination room; and/or
    - terminate the consultation at any time.
8. I agree certain situations – such as emergencies and crisis -- are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

Consent to The Use of Telehealth

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Signature: _____ Date: _____

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Psychiatric Charges

First visit or Diagnostic Interview	$ 425.00

Follow up appointments do include 2 codes combined medication management and therapy/coordination of care code together depending of complexity and amount of time spent the minimum required time for therapy/coordination is 16 min.

90833 Brief Psychotherapy 20 min	$ 100.00
90836 Psychotherapy 40 min	$ 200.00
90838 Psychotherapy 60 min	$ 300.00
99213 Medication management low complexity	$ 150.00
99214 Medication management moderate complexity	$ 200.00
90899 Telephone consult, insurance pre-authorizations, obtaining collateral information from other providers	$ 50.00
90899-21 Letter	$ 60.00
90899-22 Prescriptions Refill by e prescribe	$ 35.00
Late Cancellation fee or no show fee (if 48 hours notice not given) All cancellation has to be done via email in timely fashion.	$ 100.00
Release of old records to another provider	$ 75.00

Please note that late cancellation and no-show fees, prescription refill by e-prescribe, old records being send to new provider, obtaining collateral information and consultations with another provider, telephone consultations, collection agency fees, are not covered by healthcare insurance benefits, and will be the patient's / parent's personal responsibility. Insufficient Funds (NSF) returned checks $60.00

Dated_____ Signature of participant_____