

General Office Policies

Thank you for the trust you have placed in us by choosing Ivy Collaborative Healthcare for your health care needs. We are committed to providing you with the highest quality of patient-oriented, goal focused care. As part of your relationship with Ivy Collaborative Healthcare, a clear understanding of our office policies is essential. This allows you to become familiar with the office procedures, your individual responsibilities, financial liability, and the extent and limits of various forms of communications. We reserve the right to change this notice. We reserve the right to make the revised notice effective for medical information we already have about you as well as any information we receive in the future. Current office policies are also listed on our website, www.ivycollaborative.com. Please take your time to review and fully understand this document. If you have any questions, please call us before signing. Please initial where designated to indicate that you have read, understand, and agree.

Appointment Policy

- The initial appointment is considered a consultation visit. Your clinician will determine if our services will be appropriate to meet your needs. If our providers are not appropriate for your care for any reason, please contact your insurance for other resources.
- As a courtesy, you may receive a reminder call/text/email ahead of time to confirm your appointment.
- Your appointment is subject to personal accountability and responsibility in keeping and managing the session.
- **An appointment is considered a mutual agreement between you and your clinician, and it has been reserved for you.** Every effort is made to see you on time. We do not double-book our schedule.
- **Please arrive 15 minutes prior to each scheduled appointment to complete any documentation, assessments, screeners, etc. Gathering this relevant information ahead of time permits us to focus during the visit and allows you to provide input into your care.**
- If you are more than ten (10) minutes late for your appointment, your clinician may not have the necessary amount of time for proper evaluation and your session may require rescheduling. You will be charged a missed appointment fee. Appointments for which you arrive late and are seen will still end at the appointed time. If you are ill or have another emergency, please notify the office as soon as possible.
- All **new** patient appointments will require a \$100 appointment hold fee that will be applied to your co-pay, deductible, or co-insurance at your first and second visit. Any credit balance from that appointment hold fee can be refunded at the 3rd visit after insurance is billed and copays/deductibles are satisfied, or the funds can be maintained to apply towards any future charges, at your discretion.

Agree and Initial Here: _____

Cancellation/Missed Appointment Policy

- If you are unable to keep a scheduled appointment, you must call at least **24 hours** in advance, or we may consider you a "no-show".
- If you are an established patient and miss your appointment, the patient/guardian is subject to a "No-show/Late cancellation" fee of \$50. New patients are subject to a fee of \$100. Your insurance company does not cover charges for missed appointments. This fee will need to be paid in full before future services are provided.
- **Not receiving the reminder call/text/email is NOT a valid reason for not coming to your appointment since this is a courtesy.**

Agree and Initial Here: _____

Charges

Payment is due at the time of service. We accept CASH or CREDIT CARD (American Express, Visa, MasterCard, Discover). Please bring exact change as the office does not carry cash.

- We encourage patients to keep a credit card on file to make the checkout process easier, faster, and more efficient. At check-in, we will scan the credit card of your choice, including your Flexible Spending Account (FSA) or Health Savings Account (HSA) card. After your insurance has paid their portion, we will notify you via email of the balance owed, charge the balance owed to your card on file, email a receipt for the charge. Your credit card information will always be fully protected by our off-site, card-processing partner Elavon, and not on our computers.
- Current Cash Rates for Self-Pay or Out-Of-Network: are listed below. A Good Faith Estimate will be provided upon request.
New Patient Evaluation: Total Charge or Minimum \$200 Deposit Follow-up Visit: Total Charge or Minimum \$150 Deposit
- There will be charges for services provided outside of individual appointments. An example list of forms along with costs to complete are detailed below under the Forms/Letters/Record Requests section.
- **Failure to receive your statement does not relieve you of your financial obligations.**
- It is your responsibility to notify the office with any changes to your billing information.
- Past due accounts are subject to our collections process and dismissal as a patient from our clinic.
- A fee will be charged for the completion of forms and letters.
- A \$50 fee will be charged for Non-Sufficient Funds (NSF) checks, and any fees from your bank.

Agree and Initial Here: _____

Patient Portal

Ivy Collaborative Healthcare offers its patients the opportunity to communicate via the secure Patient Portal. Through the Patient Portal, you can access your personal health information and test results, securely message your care team, manage payments, all from one spot, and at your convenience, 24/7. You can also review prescription medication and request renewals. Do NOT send emails to any email address you may have found. Contact the Patient Support Team at 1-888-774-8428 for assistance with the Patient Portal.

- When sending communication via the Patient Portal, please put the subject of your message in the subject line so that we can process it more effectively. Be sure to include a return telephone number.
- The patient/guardian is responsible for protecting his/her password or other means of access to the Patient Portal. Ivy Collaborative Healthcare is not liable for breaches of confidentiality caused by the patient/guardian or any third party.

Agree and Initial Here: _____

Medication Refills

- Our policy is to provide enough medication/refills to last until the date of the next scheduled appointment. It is the patient/guardian's responsibility to remain current with their appointments so that there is no lapse in needed medications. Please inform your clinician about refills required and allow at least three (3) business days before your medication runs out. It is advised to set aside an emergency reserve of three to five days of each prescription.
- It is required that **all requests for medication refills be submitted via the patient portal**. No calls to the office requesting medication refills will be accepted. You can sign up for the patient portal at www.ivycollaborative.com, select "Patient Resources", select "Become a Patient", then select "Sign up for our Patient Portal". We do not accept refill requests from Pharmacies.
- If a patient runs out of medications due to a missed appointment:
 - The non-controlled medication(s) will be refilled one time only (if deemed clinically appropriate by the treating clinician) until the next available appointment.
 - The controlled medication(s) will be refilled one time only for up to 30 days (if deemed clinically appropriate by the treating clinician) and an appointment must be made within that timeframe to be evaluated in person.
- Medication refills will **NOT** be performed in the following cases:
 - After office hours (including possibly late Friday afternoon requests)
 - Over the weekend
 - During holidays
 - For patients who repeatedly miss their scheduled appointments
 - If there is a suspicion of abuse of medications or failure to comply with drug screen requirements.
- Our clinicians reserve the right to refuse to refill any medication if they believe it is clinically necessary to evaluate the patient before prescribing the medication.

Agree and Initial Here: _____

Prior Authorizations

- Ivy Collaborative Healthcare will perform prior authorizations. Please note that this process may take up to seven (7) business days. In some cases, your assistance may be needed in obtaining the prior authorization if your payor does not respond in a timely manner. It may be helpful to bring a copy of your insurance company's preferred drug list. Please check with your pharmacy and/or insurance company for the results of prior authorizations.

Agree and Initial Here: _____

Telephone Calls

- Please call the office with any urgent clinical questions. Leave your full name, patient's name and phone number with your message. Calls will be returned within 72 business hours, or earlier if possible. Any non-urgent matters, such as a routine need for medication changes in dose or formulation, therapeutic issues, or any other non-urgent concern, must be addressed during appointment times.
- Please do NOT leave a message in case of emergencies. See the emergency procedure below.
- There is no charge for brief phone calls (<5 minutes) with the clinician. If a phone call does last for more than 5 minutes, it will be billed at a pro-rated rate.
- Text messaging is NOT an acceptable form of communication.
- Please note that our providers cannot be interrupted while treating others to take your calls.

Agree and Initial Here: _____

Virtual Visits (Telemedicine)

For insured patients, all virtual visits charges will be presented to your insurance for payment, as a courtesy. If your insurance does not cover Virtual Visits (Telemedicine) or if you are uninsured, you will be charged \$95, which is due at the time of the Virtual Visit. You must be physically located in the state(s) where your clinician is licensed at the time of the appointment. The patient cannot be driving, in a moving vehicle, engaged or distracted by another activity. Failure to do so will result in rescheduling the appointment and a \$50 fee.

Agree and Initial Here: _____

Confidentiality Policy and Limits of Confidentiality

- This practice operates in a “multi-disciplinary” way. Meaning, the clinicians function as a team. It is essential to understand that the information in the chart is accessible to other providers in the office in order to provide you with high quality and consistent care.
- Review the HIPAA privacy notice located on the website at www.ivycollaborative.com.
- You may complete the Authorization for Release of Medical Information to authorize disclosure of your health information to a designated individual, company, agency or facility. The form is located on the practice’s website at www.ivycollaborative.com under the “Patient Resources” tab.
- Children (under the age of 18) have the right to confidential one-to-one sessions with clinicians. This is necessary to build a trusting relationship with the child. However, if there are issues that pose a grave or immediate danger, they may be discussed with parents or legal guardians or child protective services.

Agree and Initial Here: _____

Emergency Treatment Policy

- In the event of an emergency (immediate attention is required for oneself or another due to a life-threatening situation or a potential threat to safety), call 911 or go to the nearest hospital emergency department for immediate services. You may also call:
 - Georgia Crisis and Access Line at 1-800-715-4225
 - National Suicide Prevention Lifeline at 1-800-273-8255 (1-800-SUICIDE)
 - Veterans Crisis Line at 1-800-273-8255, then Press 1 (1-800-TALK, then press 1) or text 838255

Agree and Initial Here: _____

Conduct and Dress Code Policy

- Patients/guardians are required to adhere to clinic policies.
- Appropriate clothing and shoes are expected to be worn by patients/guardians.
- Disrespectful, abusive behavior or harassment towards office staff will not be tolerated and patients are to expect that they will be terminated from the practice for this sort of demeanor.

Agree and Initial Here: _____

Items Not Allowed

- The use of tobacco products, vaping, e-cigarettes or any illicit drugs is not allowed on clinic grounds.
- Weapons or firearms are not allowed on clinic grounds.
- Food and/or beverages are not allowed on office premises.

Agree and Initial Here: _____

Drug Screening Policy

Drug screens are performed on patients when deemed necessary by the clinicians. All patients who are prescribed controlled substances either by medical staff or any other third-party providers will be subject to drug screenings. Any charges that may result from the drug screen will be the patient’s responsibility, if not covered by their insurance policy. If you are prescribed a controlled substance and do not comply with a pill count or drug screen within 48 hours, you may be terminated from the practice. If you receive controlled substances from another prescriber and do not notify the clinic, you will be terminated from the practice.

Agree and Initial Here: _____

Forms/Letters/Record Requests

- It is required that all requests for forms, letters, or medical records be submitted via the patient portal. No calls to the office requesting a form will be accepted. You can sign up for the patient portal at www.ivycollaborative.com, then select “Patient Resources”. The Authorization for Release of Medical Information form may be printed off the website and submitted to your clinician prior to the form being completed. These requests require at least ten (10) business days for completion. It is the patient/guardian’s responsibility to provide sufficient advanced notice. We do not fill out paperwork for any organization unless you have been a patient for 6 months or longer or have been seen a minimum of 6 times. We do not write letters in support of an Emotional Support Animal. We do not perform disability evaluations or fill out paperwork for short-term or long-term disability or workers compensation.
- Please be advised that there is a fee for any patient forms which require your provider to complete them. Payment must accompany the form. We accept payment via credit card, debit card, or cash (exact amount). Do not send cash via mail. Fees are as follows:

Disability Assessment Forms	\$30	Diagnostic and Treatment Update Letter	\$20
-----------------------------	------	----------------------------------------	------

FMLA Forms	\$30	Insurance Forms	\$30
Home Health Form	\$30	Jury Duty Accommodation Letter	\$20
Home Bound Form	\$30	Disabled/Handicap Form	\$30
Customized Letter	pro-rated		

Agree and Initial Here: _____

Dismissal Policy

- After three (3) missed appointments/no-shows within one (1) calendar year (365 days), the clinician reserves the right to dismiss patients from Ivy Collaborative Healthcare due to treatment non-compliance. Other possible reasons for dismissal include but are not limited to noncompliance with the treatment plan or medical advice, verbally abusive, disrespectful, threatening or harassing behaviors toward any of our staff, failure to pay your outstanding balance.
- If you are dismissed from the practice, you can no longer schedule appointments, obtain medication refills or consider us your clinician/provider. You must find a provider in another practice. A letter will be sent to your last known address, notifying you that you are being dismissed. If you have a medical emergency within thirty (30) days of the date on the letter, we may assist you with your care concerns.

Agree and Initial Here: _____

Minor Children

A minor child MUST be accompanied by his/her legal guardian for appointments. Stepparents are NOT legal guardians. Whomever brings a child to be seen is responsible for payment at the time of service. It is the custodial parent's responsibility to arrange reimbursement from the non-custodial parent.

Agree and Initial Here: _____

Supplemental Financial Policy

Thank you for choosing Ivy Collaborative Healthcare for your health care needs. We are committed to providing you with the best possible care and to your treatment being successful. To achieve this outcome, we must emphasize that our relationship is with you, not your insurance company, as your mental health provider. We will bill your insurance company as a courtesy if you are covered under certain participating insurances. **It is the patient/guardian's responsibility to contact the insurance company to ensure that your clinician participates in your plan and answers any questions concerning your coverage. It is also your responsibility to understand your coverage and benefits.** We are not responsible for knowing the requirements of your specific plan. We will try to assist you to ensure that all plan requirements are met. Ultimately, the patient/guardian, is financially responsible for any services provided by our office that are not covered by your plan. This Financial Policy supplements and does not replace the Privia Medical Group Financial Policy.

Please make a note of the following items:

- At the time of service, proof of current/valid insurance and identification must be provided. If you are unable or do not provide this information, you will be considered a self-pay patient. A Good Faith Estimate can be provided upon request.
- We are happy to file claims to your health insurance, but will not file automobile, general liability, homeowner's or workman's compensation insurance.
- If you have HMO/POS insurance, it is your responsibility to obtain a referral number from your primary care provider (PCP) before being seen by our providers. If you fail to obtain this information, the bill will be your responsibility and you will be required to pay the full charge prior to being seen.
- There will be charges for services provided outside of individual appointments (e.g. lengthy telephone calls made by the clinician, provider fee forms, etc.)

Please understand that payment of your bill is considered part of your treatment. I certify that I have read and understood the General Office Policies, Financial Policy and Supplemental Financial Policy, was given the chance to ask my questions and have them answered. I agree to abide by the policies set forth. I understand that if I do not sign this consent described above, then the practice will not treat me or my child. My signature denotes that I agree to pay for services under the conditions and specifications outlined in this billing policy. I confirm that I have an active health insurance policy in place. I agree to update this information immediately if my health coverage changes or is terminated and agree to pay any fees for visits if I fail to do so. I also acknowledge that I am responsible for payment of all services provided, regardless of insurance coverage.

Patient Signature: _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Date: _____

Printed Patient Name: _____