Ira Phillips, MD
1505 54th Ave N, Ste 302
Nashville, TN 37209
P 615.558.5768; F 888.501.4893
http://www.iraphillipsmd.com/

Clinic Policies:

Clinic Hours:
Office hours are by appointment only. Please call for general concerns (appointments, billing, non-urgent medications refills) from 8am-5pm Monday-Friday.

Emergencies / After Clinic Hours:

- For emergencies (significant worsening of symptoms and especially thoughts of harming yourself or others), please **call 911 or go to the nearest emergency room**. Once there, please call me at **615.558.5768**.
- If you have a concern that is not an emergency but needs to be promptly addressed, please call me at **615.558.5768**.
- **Other methods of communication including but not limited to email, text, fax, other clinic/cell phone numbers, and patient portal messages are not checked after clinic hours. Do not use these for emergent or urgent communications.**

Medication Refills:
If you need a refill of a medication, please communicate with me directly--ideally through Spruce during business hours.

Electronic Communications:
Email, text, and other means of electronic communication are not necessarily secure and could result in a breach of your privacy. Due to this vulnerability, **I recommend that you use the secure messaging feature in Spruce**.

If you choose to send or ask that I send other communication, I will respond and understand you accept and are aware of these risks. All messages will be saved as part of your medical record.

___ **(initial)** I have read and agree with the electronic communication policy.

___ **(initial)** I authorize Dr. Phillips to leave detailed voicemail related to my treatment.

Ending Treatment:
Patients are not obligated to continue treatment; however, if you decide to end treatment, you are encouraged to discuss your decision with Dr. Phillips first. Sometimes discussing this decision can be an important part of your treatment. While I take steps to avoid, in very rare cases, I may need to end treatment with you (examples include disruptive behavior in the clinic/pharmacy, frequent and/or especially dangerous nonadherence to treatment, doctor shopping for controlled substances, frequently missed appointments, repeated lack of payment, and other similar behaviors).

If you cancel your follow-up appointment and are not seen as planned, I will attempt to contact you. If I do not hear back within 30 days, I will formally close your case. You are welcome to return, though we will need to complete a new evaluation to open your case.

Insurance Policy:
I am an out-of-network provider for all private insurance coverage. You are welcome to submit your bill to your insurance company for out-of-network coverage; I do not submit to your insurance company.

Payment Policy:
Payment is collected at time of service. For patients seen multiple times per month, you may elect to be billed monthly. Payment is by cash, check, or credit/debit.

Returned Payments:
If you make a payment that is not honored by your financial institution, I will charge you a returned payment fee to recover the costs of the returned payment.

Late Payments:
While I understand that payments can be late from time to time, I reserve the right to charge a late payment fee for recurrently late payment. Details will be discussed as part of your treatment if this occurs.

Other Services:
All time spent outside of regularly scheduled appointment time including time extension of appointments is billed at my hourly rate. This includes but is not limited to phone calls (to you or other providers), paperwork to be completed, prior authorizations, refills between appointments if recurrent or time-intensive, emergency services, court cases, or any appearance on your behalf.

Disability, Court, and Other Evaluations:
As your treatment psychiatrist, my role is to help you make positive changes in your life. I do not provide formal (forensic) evaluations for long-term disability, courts, or

other similar situations. Should you need such an evaluation, I will assist you in referral to a forensic psychiatrist (who will evaluate but not treat you) and provide a copy of your treatment records. Maintaining this separation is consistent with ethical guidelines and protects your treatment.

Appointment Charges and Cancellation Policy:
I do not overbook appointments, and your appointment time is reserved for you. Patients will be charged if they miss their appointment or do not cancel with more than 24 hours' notice.

Confidentiality:
Confidentiality is an important part of treatment; and I take many steps to keep your information private. However, I am required by law to report and/or take action to provide safety for certain situations (risks to self or others, child abuse, elder abuse, doctor shopping for controlled medications, reportable diseases). Also, I review my work with a psychotherapy supervisor and colleagues to improve the quality of your treatment; for this, I take steps to disguise your identity. If you have questions about confidentiality or other clinic policies, please ask.

Consent for Treatment and Patient/Guarantor Responsibility:
I have read the policies listed above, and I understand and agree with them. I agree to be treated by Ira Phillips, MD, and when necessary, any doctors covering in his absence. I agree that I am responsible for all charges for services rendered, and I agree to adhere to the payment policies.

Patient's Signature: _____ Date: _____

Patient's Name: _____

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Privacy Practices Acknowledgement:
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to contact, plan, and direct my treatment and follow-up with multiple health care providers who may be involved in that treatment directly and indirectly. Also, I understand that this information can be used to conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such notice of privacy practices prior to signing this consent. I understand that this organization has the right to change its notice of privacy practices from time to time and that I may contact this organization at any time to obtain a current copy of the notice of privacy practices or obtain one from your website (http://www.iraphillipsmd.com/).

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken actions relying on the consent.

Patient's Signature: _____ Date: _____

Patient's Name: _____

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Guarantor Information (Complete only if the patient is NOT paying for the bill)

Name of Guarantor _____

Relationship to Patient: _____ Phone: _____

Address: _____

City/State/Zip Code: _____

Date of Birth: _____ SSN (Last 4): xxx-xx-_____

Guarantor-Financial Responsibility Agreement: I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges generated for this patient. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that unpaid balances over 90 days past due may be referred to a collection agency. I understand that if I do not want my credit card billed, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date: _____

Credit/Debit Card Payment Authorization:

I/we authorize Ira Phillips, MD, to bill my credit/debit card on file for professional services at the time of scheduled service (including missed appointments or appointments cancelled with less than 24 hours' notice). I understand that there are charges for service provided outside of regular appointment times. I will notify Ira Phillips, MD, in writing if I no longer want my credit/debit card billed. Regardless, I understand I am still responsible for all fees incurred during treatment.

Signature of Cardholder _____ Date: _____

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