XIAOHUA FENG, MD

OFFICE POLICIES

Welcome and hello. It can be intimidating to seek help. My goal is to create a safe and welcoming environment for treatment. I will try my best to be of help to you. If you have any questions about the contents of this document, or any other aspects of your treatment here, please bring them up when we meet.

This agreement contains important information about the practice's professional services and business policies as well as information required by the Health Insurance Portability and Accountability Act (HIPPA). When you sign the signature page, it will represent an agreement between you and XIAOHUA FENG, MD.

APPOINTMENTS AND CANCELLATIONS

I schedule appointments myself. I try to offer prompt and flexible appointment times. If you are calling/emailing to schedule or reschedule an appointment, please leave me some dates and general times that will work best for you. If you cannot keep an appointment or only give a brief notice before canceling, it creates an inconvenience for me and other patients who are waiting for appointments. **Therefore, if I do not have 24 business hours notice about a cancellation, you will be charged for that time. No-shows will be charged the full rate, and repeated no-shows may result in termination of treatment.** Keep in mind that insurance companies do not reimburse for missed sessions.

FEES AND PAYMENTS

Fees are discussed prior to starting treatment. Patients pay for their treatment at the time of each visit unless other arrangements are made with me. I accept Zelle (an electronic payment system used by many major banking institutions), check, cash, or credit card. Checks can be made payable to "Chicago Psychiatric Partners LLC". Any legal fees or costs necessary to collect unpaid balances will be your responsibility.

Please note that a credit card number is requested at the initiation of treatment, and will be kept on file, in order to ensure prompt payment. I will always inform you when I am billing your credit card.

Rates: Please contact me for current rates
Initial consultation:
45 minutes or 90 minutes
Follow-up appointments:
45 minutes for therapy/meds
30 minutes for meds only

INSURANCE OR MANAGED CARE

I am in-network with BCBS PPO. I am not in-network with Blue Choice. **I do not confirm coverage or benefits. Clients are strongly encouraged to contact their insurance company prior to scheduling an appointment to confirm coverage and expected costs of treatment. You are responsible for any associated deductible, co-insurance, co-pay, out-of-network costs, and will be billed accordingly.**

I do not participate with other insurance plans but will provide statements in support of reimbursement using out-of-network benefits, if available to you. Many health insurance plans offer generous out-of-network benefits that can make high-quality treatment affordable and accessible. I will supply the necessary documents for reimbursement filings. Insurance coverage is a contract between you and the insurance company. I cannot resolve conflicts between you and them.

Medicare and Medicaid: I do not participate in either of these programs and if you receive treatment from me it will not be covered by these programs. If you are a Medicare beneficiary and decide to pay privately for treatment with me, you must sign an agreement describing that understanding, which is required by Medicare. I have such forms available.

In assessing the out-of-pocket cost of treatment, it is helpful to be familiar with the following concepts, which I encourage you to discuss with your insurance company:

- Your plan's **annual deductible** (the amount for which you are responsible before insurance shares the cost)
- Your **co-insurance** (the percent contribution your plan expects you to make – often on the order of 25% or 30%, after you meet your annual deductible)
- Your **annual out-of-pocket maximum** (the maximum out-of-pocket expenditure you would be expected to make during the year – generally, the sum of your deductible and co-insurance contributions). Once the out-of-pocket maximum contribution has been satisfied, most plans will reimburse allowed charges in full for the remainder of the calendar year.
- Is there a limit per year, e.g. number of sessions, dollar amount?
- Does your insurance company require precertification (pre-approval)?

PRESCRIPTIONS AND REFILLS

If I am providing medications as part of your treatment, I will either provide a written prescription when we meet or call in the prescription to your pharmacy after our appointment. We will always try to schedule appointments before you run out of medications.

On occasion, you may run out of medications before a return appointment. If that happens, please call me as soon as you notice that you will not have enough medication to last until our next appointment. Please do not make requests over email. When calling for this reason please leave me the following information:

- The name and exact dose and frequency of the medications.
- The name, address, and phone number of a pharmacy convenient for you.
- Phone numbers where I can reach you if I need to clarify anything.

I will call in a refill as soon as possible, but please allow for at least 3 business days. I ask that we not do this routinely since I need to meet with patients on a regular basis to monitor the medication treatment.
Please note that I do not prescribe any medication to a patient who has not been seen in more than 3 months without an appointment. It is your responsibility to ensure that you have appointments scheduled in a timely fashion. There will be no exceptions to this rule. If you are requesting a refill and have not had an appointment in the past 3 months, you will need to schedule an appointment at that time as well.

625 N MICHIGAN AVE | SUITE 1910 | CHICAGO, IL 60611
737 N MICHIGAN AVE | SUITE 1200 | CHICAGO, IL 60611
SFENGMD@GMAIL.COM | T: 312-588-6200 | F: 832-621-0428

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CONTROLLED SUBSTANCE POLICY

I prescribe extremely limited controlled substances in my practice. Controlled substances include benzodiazepines (i.e. Xanax, Ativan, Valium) and stimulants (i.e. Ritalin, Adderall, Vyvanse).

I do not:

- Prescribe benzodiazepines to patients who are taking daily opiate medications
- Prescribe benzodiazepines to patients who are taking stimulant medications
- Prescribe high dose or long-term benzodiazepines
- Prescribe controlled substances to patients who use marijuana or illicit substances
- Replace lost or stolen prescriptions of controlled substances without a police report
- Prescribe controlled substances if you are receiving them from another physician

EMERGENCIES

In the event of a medical emergency, please call 312-588-6200, follow the instructions, and present to the nearest hospital emergency room or call 911. It may not be possible for me to respond immediately and it is important that treatment not be delayed in cases of emergency.

CREDIT CARD INFORMATION

NAME ON CARD: _____

CARD NUMBER: _____

SECURITY CODE: _____

EXPIRATION DATE: _____

BILLING ADDRESS: _____

AUTHORIZATION TO CHARGE CARD (INITIAL HERE): _____

I have read this treatment agreement. I have received satisfactory answers to all the questions I have asked regarding its contents. I agree to abide by the terms set forth in this agreement.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

(continue on to next page for Privacy Practices)

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NOTICE OF PRIVACY PRACTICES

I make every effort to maintain and respect the confidentiality of information about my patients. There are rare circumstances, however, in which the law may require that I release information about you, without your authorization. Examples of such circumstances are, 1) if I have reason to believe that you pose a direct threat of imminent harm to a person (including yourself), 2) if I have reason to suspect that abuse or neglect of a child, an elder, or a dependent/disabled person is taking place, and 3) if I am required or ordered to do so in the course of a legal proceeding (court order/subpoena). I also reserve the right to use and disclose information about you if I believe that doing so is necessary to defend myself in legal action brought against me in relation to your care.

I am in-network with BCBS PPO and submit documentation directly to the insurance company. This requires a diagnosis and description of services rendered.

I do not deal directly with other insurance companies. If you choose to seek reimbursement using your out-of-network health insurance benefits, your claim will require a diagnosis and description of services rendered. I will supply you with invoices that include specific diagnostics and treatment information, suitable for submission in support of your claim.

I communicate with patients via telephone, email, and text message, none of which is secure and I, therefore, cannot guarantee the confidentiality of communication by these means. Unless you advise me otherwise, I may use any or all these means to communicate with you and your consent for me to do so is implied. This permission may be revoked by you at any time.

I have received and reviewed the above notice of privacy practices.

SIGNATURE: _____

PRINTED NAME: _____

DATE: _____

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