Signed On: https://wellmind.com/

Treatment Agreement

WellMind with Dr. McGee
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Treatment Agreement

IMPORTANT *Please keep a copy of this document in a safe place for future reference.*

Confidentiality

In general, the law states that all communications between a psychiatrist and his patients are confidential. Any information shared requires your verbal or written permission. You should be aware, however, of the following exceptions to the professional responsibility for maintaining confidentiality:

1. In some child custody or adoption proceedings;
2. If you were to make your own mental or emotional health an issue in a court case;
3. In circumstances in which, to the best of my professional judgment, I believe there is a chance you may harm yourself or another person;
4. If I have reason to suspect a child or elderly person is being abused;
5. When using third party reimbursement, I will have to provide your insurance company with a diagnosis. I may also need to share information about your clinical status, your treatment plan, and your response to my treatment;
6. If your account is overdue and arrangements for payment have not been negotiated, a collection agency will be provided with dates of service, type of service provided, and total amount due.

If any of the above circumstances were to occur in the course of our work together, I would remind you of my legal obligations and discuss the situation with you before taking action.

I may consult with a colleague about our work together, who is bound by the same laws of confidentiality as I am. You agree to provide your unrestricted and open-ended consent for me to speak with any of your other therapists, doctors or other caregivers as long as you are under my care.

When treating adolescents, I discuss general issues with parents. However, I discuss the specifics of treatment only with the adolescent’s permission.

Fees

Standard Fees

Service	Fee
Initial Visit Fee	$540
50 minute visit	$300
20 – 25 Minute visit	$180
Other fees: Telephone calls, email messages, other activities (such as report generation, legal work, time to obtain medication insurance authorizations, etc.)	$360/hour, billed in six minute increments, (no charge for calls or work less than five minutes)

Payment Policy

You must pay your balance in full when you see me. Payment must be by credit card, cashier's check, or money order in advance of your session. I require an active/valid credit card or debit 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 administrative work, sessions, concierge fees, and clinical work between sessions. WellMind does not take personal checks. Failure to pay your account balance will result in suspension of your treatment until any balance due is paid.

Cancellations

We do not charge for canceled appointments provided you give a minimum of one business day's notice. We do charge full fee for cancellations with less than one business day's notice. We make exceptions to this policy only in extreme circumstances beyond your control.

Health Insurance

We do not accept health insurance, however, upon request we will supply patient statements to submit to your insurance company for reimbursement if you have out-of-network benefits, as Dr. McGee would be considered an out-of-network provider. Please check with your insurance carrier.

Emergency Coverage

We do not provide emergency coverage. In an emergency, go to your nearest emergency room or call 911.

Patient Responsibilities

You understand that I reserve the right to discontinue your treatment if, in my professional judgment, I do not

feel it is helpful to you. You agree to follow through with treatment plans we agree on, and to let me know if you feel your treatment is not helpful and needs to be changed.

You enter into this treatment with the understanding that we will work together to maximize your well-being. You will let me know if you are ever feeling unsafe so that we can work together to prevent any harm befalling yourself or others.

You understand that I may end your care if I find that you have:

1. Given or sold your medications to another person;
2. Taken you medications other than as prescribed;
3. Not paid your bill.

You understand that treatment requires honesty. No one lives life perfectly or does recovery perfectly. You need not ever experience any shame in your treatment. Mistakes are best to be used as opportunities for learning and growth. Out of your own commitment to your healing and recovery, you agree to be honest, knowing that I will not judge you and your treatment will not be jeopardized. You understand that I may end your treatment if you are not honest, as this can seriously harm your treatment.

If you are struggling with addictions, you agree to make complete recovery from all addictions (including smoking) a treatment goal. Failure to work on your recovery or to show progress in achieving complete recovery may jeopardize your treatment.

You agree to call me if you are not doing well or are in trouble. You understand that it is your responsibility to reach out and ask for help from me.

You understand that you must attend sessions reliably and on time. Regularly attending sessions late or missing appointments may result in ending your treatment.

Medications

You understand that I do not provide refills for controlled medications before they are due under any circumstances. You understand that I will not refill a controlled medication if it is lost or stolen. You must take care not to lose your medications or prescriptions. You agree to guard your medications carefully, and to store them in a secure place, such as a safe, away from access by children. If you are on a medication that creates physiological dependence, you understand that if you lose your medication you may go into withdrawal until you see me again. I will provide comfort medications for you to help sustain you until your next appointment.

I will provide prescriptions for controlled medications to last until our next appointment and generally will avoid giving refills for controlled medications between appointments. I may not prescribe medications to you if you are abusing alcohol or illicit drugs in a way that jeopardizes your safety.

You understand that I cannot prescribe controlled medications to you if I am treating you by Telepsychiatry unless we meet at least one time face to face in person.

You agree to take your medications exactly as prescribed, and not make any changes without consulting with me. You agree to not give or sell your medication to anyone, or to take anyone else’s medications.

You agree to let me know what other medications you are taking from other prescribers at all times. You agree not to obtain medications from any other physicians, pharmacies, or other sources without informing me. You agree to inform me of any changes to your medications. You agree to not obtain any psychiatric medications from any prescriber other than myself.

We periodically perform pill counts on controlled medications that I prescribe. You agree to meet with us within 24 hours of random telephone requests for a pill count session. You agree to make your medications available for counting the number of pills in your bottle(s).

You understand, that if you are recovering from an addiction, that you will be called periodically to do random drug screens. You understand that you must complete these within 24 hours in order to continue your treatment.

If you are taking a controlled medication for treatment of an addiction, you understand that drug screens are required with every visit. If you fail to provide a drug screen, you understand that you will not be prescribed any controlled medications, but may receive comfort medications for withdrawal, if indicated, until you are able to provide a drug screen. You must perform drug screens when asked except when physically unable to do so. You understand that failure to do drug screens when asked will be considered evasion and may jeopardize your treatment.

You understand that if you are receiving medications to treat an addiction, you must ACTIVELY work on your recovery to receive treatment, as medications are only a small part of the process of healing and recovery. We will work out together an individualized recovery program for you according to both your needs and your preferences.

If receiving controlled medications for an addiction, you agree to see me at least once every one to four weeks, at my discretion, based on how well you are doing. I will see you more frequently if you are not stable or are new to treatment.

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

Drug Testing

You understand that drug testing is solely to confirm an accurate assessment of your current recovery status. You understand that a positive drug screen does not necessarily jeopardize your treatment. If I prescribe controlled medications to you for a substance use disorder, you agree to submit to drug testing. This may be scheduled or random. You agree to submit to random drug tests within 24 hours of a request, and understand that failure to do so may result in termination of your treatment. You understand that any attempt to falsify or adulterate a drug screen may also result in termination of your treatment. You understand that I cannot prescribe your medication to you if you have not completed your drug test and/or I do not have the results.

Electronic Communications

You may email or text me for brief questions. You understand that emails and texts are not secure.

For sensitive clinical information, you agree to call me if you are not comfortable with text or email.

I conduct some of my practice using Telepsychiatry with a secure, dedicated telemedicine platform. You will need to have access to this platform in order for me to treat you by Telepsychiatry. You will not need this if our work is face-to-face. You must reside in a state where I am licensed in order to receive treatment from me. If being treated by Telepsychiatry, you must provide me with proof of your identity and address with a copy of a photo ID and a piece of mail with your residence address on the envelope. All sessions must be performed with you at your home address or at another verifiable address so that I know where you are located in case of an emergency.

Turn around time for all electronic communications is generally 1-3 business days. I do not monitor these when I am away, and have no coverage to monitor them. For urgent clinical matters, you agree to call me, or my coverage, when I am away.

Telephone Communications

I generally respond to telephone calls within one business day for non-concierge patients. Turnaround time for concierge patients is the same day.

Medical Records.

You have a right to view your medical record. I have the right, based on my clinical judgment of your best interests, to require that we review your record together, or to provide you with a summary of your record rather than the original record itself. I am required by law to note in your record any corrections or additions that you may request.

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 unconditional consent for me to speak with any of your other therapists, doctors or caregivers while you are under my care; and
- You authorize payment of medical benefits directly to myself for services rendered.

Date: July 17, 2019

X_____ X__

Signature Certificate

Document name: Treatment Agreement

Unique Document ID: 2EDFD4EC82BCE4513B1BC7B19B437D67C68E0957

LEGALLY SIGNED USING WPesignature

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