Hello and Welcome,

Thank you for choosing the **Institute for Advanced Psychiatry** to support your mental health and well-being. Our team is here to make your experience as smooth and supportive as possible.

To help us prepare for your visit, please complete all agreements and questionnaires **at least 48 hours before your appointment**. This allows your provider to review your information with care and attention.

Appointments & Cancellations

We understand that life happens. If you need to cancel, please let us know as soon as you can. Appointments canceled within 24 hours of the scheduled time, or missed entirely, are subject to a **$100 No-Show/Late Cancellation Fee**. If your required forms are not submitted at least 48 hours in advance, we will need to reschedule or cancel your appointment so we can offer the time to another patient in need.

Evaluation & Follow-Up Fees

Visit	Dr. Ghelber	Nurse Practitioner
Initial psychiatric evaluation (60 minutes)	$380	$365
Follow-up (up to 30 minutes)	$200	$175
Follow-up (up to 45 minutes)	$275	$260

The frequency of follow-up appointments will be mutually decided with your provider.

Dr. Casey Brian Green | Psychiatric & Addiction Care

Initial Psychiatric or Addiction Evaluation | $380 | 60-75 minutes
A comprehensive diagnostic evaluation covering substance use history, psychiatric comorbidities, withdrawal risk, medication suitability (buprenorphine, naltrexone, disulfiram, acamprosate, and medications for stimulant-use disorder), and safety planning.

Follow-Up Medication Visits | $150 for 20 minutes | $200 for 30 minutes
Visits typically include medication management, cravings assessment, relapse-prevention planning, urine drug screen review, buprenorphine induction, and therapy integration.

Dr. Casey Brian Green | Additional Services & Rates

Service	Fee
Buprenorphine (Suboxone) Induction Visit	Contact office for pricing
Extended-Release Naltrexone (Vivitrol) Injection	Contact office for pricing
Urine Drug Screening (point of care)	$20

Occupational Independent Medical Evaluation with Expert Report | $500
Includes collateral review, documentation, FAA-aligned reporting, a structured relapse-risk assessment, and a report to a monitoring agency, employer, or other applicable recipient.

Outpatient Alcohol Withdrawal Protocol | $600
Includes a CIWA monitoring plan, medication strategy (general education only), safety parameters, and daily check-ins for 3-5 days.

Genetic Testing Analysis and Interpretation | $100
Includes upload of genetic data, analysis of dopaminergic/reward pathway risk alleles, and an interpretation/report addressing risk, phenotype tendencies, and possible intervention domains.

IMPORTANT MEDICARE NOTICE

Dr. Diana Ghelber, Kai Cravey and Audra Coston have opted out of Medicare. Medicare will not pay for visits with these providers. Patients are responsible for the full cost of their visits.

Appointment Confirmation

When you consent, our scheduling system sends appointment confirmations and reminders by email and text message. As a courtesy, our office also calls approximately 24 hours before your appointment.

Thank you for trusting us with your care. We look forward to supporting you on your journey toward improved mental health and well-being.

Warmly,
The Institute for Advanced Psychiatry

Your information

1. Please enter your information.

First Name: | Middle Initials: | Last Name:

Date of Birth:

Gender:

☐ Female ☐ Male ☐ Other

Marital Status:

☐ Single ☐ Married ☐ Domestic Partner
☐ Separated ☐ Divorced ☐ Widowed

Street Address: | Apt./Unit #:

City: | State: | Zip Code:

Mobile Phone: | Home Phone: | Work Phone:

Email:

Preferred contact method:

☐ Mobile Phone ☐ Home Phone
☐ Work Phone ☐ Email

Social Security Number | Drivers License Number

Employer | Occupation

2. Preferred Language:

4. Race (Please check all that apply):

☐ White ☐ Black ☐ Asian
☐ American Indian/Native Alaskan ☐ Native Hawaiian/Pacific Islander ☐ Other

5. Ethnicity:

☐ Hispanic/Latino(a)

Communication preferences

3. Allowed Forms of Communication

Please select all methods by which you authorize our office to contact you regarding appointments, billing, treatment-related information, and other healthcare communications

By selecting a communication method bellow you authorize our office to use that method to communicate with you. Please note that email, text messages, and voicemail may not always be secure methods of communication and could carry some risk to the privacy of your health information.

- ☐ Email
- ☐ Text Message (SMS)
- ☐ Voice Message / Voicemail
- ☐ Postal Mail
- ☐ Phone Call (direct conversation)

Email Delivery of Documents — Email may be used for scheduling, administrative matters, and delivery of documents according to office policy. Would you like to receive documents by ordinary email? Choose one.

- ☐ Yes, for the documents I select below.
- ☐ No, please contact me to arrange another delivery method.

If you selected Yes, choose the documents you agree to receive by email. Check all that apply.

- ☐ Billing statements, receipts, and superbills — may include diagnosis codes, procedure codes, dates of service, and charges.
- ☐ Lab orders and lab results — may contain sensitive health information.
- ☐ Correspondence from my provider or office staff sent directly to me.

Email address on file — complete only if you selected Yes. If your email address has changed or you are unsure which address is on file, contact our office to confirm or update it before documents are sent.

- ☐ I approve sending the documents I selected to the email address registered in my patient profile with the Institute for Advanced Psychiatry.

Privacy acknowledgment — complete only if requesting ordinary email delivery. I may change my preferences by contacting the office. Declining ordinary email will not affect my care. These choices apply to documents sent to me; delivery directly to another person or organization is handled separately.

- ☐ I understand that ordinary email may not be encrypted and could be intercepted or read by others, including anyone with access to my email account. Knowing these risks, I still request that the documents I selected be emailed to me.

Patient/authorized representative signature (type your full name to confirm your selections above):

Date:

Contacts and referrals

6. How did you learn about this office?

How did you learn about this office?

Who referred you?

7. Emergency Contact:

Emergency Contact:

Relationship:

Address:

City, State & Zip:

Phone:

Alt. Phone:

8. Your healthcare contacts

Family Doctor:

Phone:

Referring Physician:

Phone:

Therapist:

Phone:

Pharmacy

Phone:

Address

9. Please list individuals with whom we may share your health information

Please list individuals (and relationship) with whom you allow us to share your health information:

Name	Relationship

Insurance information

10. Do you have medical insurance? Although we do not participate with any Insurance companies we still need your insurance information for possible future medication pre-authorization .

Please have your photo ID and insurance card available at your appointment for our records.

☐ Yes ☐ No

11. Primary Insurance

Primary Insurance Company

Member ID / Policy # Group Number

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Name Insured Phone # Insured Date of Birth

Insured Gender

☐ Female ☐ Male

Insured Street Address

Insured City Insured State Zip Code

Do you have secondary insurance?

☐ Yes ☐ No

12. Secondary Insurance

Secondary Insurance Company

Member ID / Policy # Group Number

Client Relationship to Insured

☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Name Insured Phone # Insured Date of Birth

Insured Gender

☐ Female ☐ Male

Insured Street Address

Insured City Insured State Zip Code

Reason for your visit

13. Authorization

I authorize the release of any medical information necessary to process medication prior authorizations .

Signature

Date

14. Problem 1:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?

☐ Mild ☐ Moderate ☐ Severe

Have you tried anything to treat this problem?

15. Problem 2:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?

☐ Mild ☐ Moderate ☐ Severe

Have you tried anything to treat this problem?

16. Problem 3:

Please describe the issue you're experiencing:

How long have you had this problem?

How severe is this problem?

☐ Mild ☐ Moderate ☐ Severe

Have you tried anything to treat this problem?

17. How would you rate your health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Review of systems 1 of 2

Do you have any problems with the following? Please check the correct box:

18. Constitutional

- ☐ Lethargy
- ☐ Fevers/Chills
- ☐ Unexplained weight loss
- ☐ Unexplained weight gain
- ☐ Night Sweats

19. Neurological:

- ☐ Confusion
- ☐ Dizzy/Lightheaded
- ☐ Headaches
- ☐ Memory problems
- ☐ Narcolepsy

20. Eyes:

- ☐ Blurry/Double Vision
- ☐ Burning
- ☐ Redness
- ☐ Loss of Vision

21. Ear/Nose/Throat:

- ☐ Congestion
- ☐ Ear Pain
- ☐ Facial pain/numbness
- ☐ Hoarseness
- ☐ Nose bleeds
- ☐ Sinus pain
- ☐ Ringing in the Ears

22. Respiratory:

- ☐ Blood in Sputum
- ☐ Persistent Coughing
- ☐ Shortness of Breath
- ☐ Sleep Apnea
- ☐ Snoring

23. Cardiovascular:

- ☐ Angina/Chest Pain
- ☐ Ankle Swelling
- ☐ Exercise Intolerance
- ☐ Heart Palpitation
- ☐ Leg Pain with Walking
- ☐ Wake Short of Breath

24. Gastrointestinal:

- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Black Stool
- ☐ Bloating
- ☐ Constipation
- ☐ Diarrhea
- ☐ Food Intolerance/Sensitivity
- ☐ Heartburn
- ☐ Nausea/Vomiting
- ☐ Stool Incontinence

Review of systems 2 of 2

Do you have any problems with the following? Please check the correct box:

25. Genitourinary:

- ☐ Blood in urine
- ☐ Nighttime urination
- ☐ Heavy/Painful Menses
- ☐ Infertility
- ☐ Impotence
- ☐ Prostate Problems
- ☐ Urine Incontinence

26. Allergy/Immunology:

- ☐ Frequent Infections
- ☐ Past Anaphylaxis
- ☐ Seasonal Allergies
- ☐ Swollen Glands

27. Hematology:

- ☐ Bleed/Bruise Easily
- ☐ Blood Clots
- ☐ Past Blood Transfusion

28. Musculoskeletal:

- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Pain

29. Skin/Breast:

- ☐ Breast Lump
- ☐ Skin Rash

30. Psychiatric

- ☐ Depression
- ☐ Anxiety
- ☐ OCD
- ☐ Eating disorder
- ☐ PTSD
- ☐ Bipolar disorder
- ☐ ADHD

Medical history 1 of 2

31. Do you have now (or have you ever had):

Condition	Yes	No	Past
Anxiety	☐	☐	☐
Asthma/Emphysema	☐	☐	☐
Arthritis	☐	☐	☐
Blood Clots	☐	☐	☐
Bowel disease	☐	☐	☐
Chronic Pain	☐	☐	☐
Depression	☐	☐	☐
Diabetes Type I	☐	☐	☐
Diabetes Type II	☐	☐	☐
Eye Disease	☐	☐	☐
Heart Attack/Angina	☐	☐	☐
Heart Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
High Blood Pressure	☐	☐	☐
Immune Disorder	☐	☐	☐
Kidney Disease	☐	☐	☐
Kidney Stones	☐	☐	☐
Liver Disease	☐	☐	☐
Migraines	☐	☐	☐
Neurologic Disorder	☐	☐	☐
Osteoporosis	☐	☐	☐
Recurrent Infections	☐	☐	☐
Seizures/Epilepsy	☐	☐	☐
Stroke/TIA	☐	☐	☐

Medical history 2 of 2

31. Do you have now (or have you ever had):

Condition	Yes	No	Past
Thyroid Problems	☐	☐	☐
Vascular Disease	☐	☐	☐
Acid Reflux	☐	☐	☐
Cancer	☐	☐	☐
Headaches	☐	☐	☐
Fatigue	☐	☐	☐
Blurred Vision	☐	☐	☐
Loss of Vision	☐	☐	☐
Chest Pain	☐	☐	☐
Shortness of Breath	☐	☐	☐
Blood in sputum	☐	☐	☐
Constipation	☐	☐	☐
Diarrhea	☐	☐	☐
Urinary Problems	☐	☐	☐
Blood in Stool	☐	☐	☐
Skin Rash	☐	☐	☐
Nausea/Vomiting	☐	☐	☐
Weight loss/ gain	☐	☐	☐
Hot Flashes	☐	☐	☐
Back Pain	☐	☐	☐
Joint Pain	☐	☐	☐
Insomnia	☐	☐	☐
Mood Change	☐	☐	☐
Memory Loss	☐	☐	☐

32. If YES to any of the above, please explain:

Surgery and medications

33. Surgery?

☐ Yes ☐ No

34. Please list your previous surgeries:

Operation	Month/Year

35. Past Medications:

Medication Name	Dosage	Frequency	Reason for taking

36. Current Medications:

Medication Name	Dosage	Frequency	Reason for taking

Blood thinners and allergies

37. Blood thinning medications?

☐ Yes ☐ No

38. Allergies?

☐ Yes ☐ No Known Allergy

39. If yes, please list including reaction:

Allergy	Reaction

40. Shellfish/Iodine/IV contrast?

☐ Yes ☐ No

If yes, reaction:

41. Latex?

☐ Yes ☐ No

Reproductive history

42. FEMALES:

Date of Last menstrual period:

Age at first period:

Are you on contraceptives? ☐ Yes ☐ No

If yes, please name:

Menopause?

Hysterectomy?

Ovaries removed?

Hormone replacement? ☐ Yes ☐ No

List:

# of Pregnancies:

# of C-Sections:

# of Vaginal:

# of Abortions:

# of Miscarriages:

Pregnancy Complications: ☐ Yes ☐ No

If yes, please explain:

Date of last pap smear:

Abnormal pap smear(s)? ☐ Yes ☐ No

Date of last mammogram:

Abnormal? ☐ Yes ☐ No

43. MALES:

	Yes	No
Vasectomy?	☐	☐
Impotence?	☐	☐
Erectile Dysfunction?	☐	☐
Weak urine stream?	☐	☐

Last PSA result:

Prostate Exam:

Health and daily habits

44. Do you: Smoke?

☐ Yes ☐ No ☐ Past

If past, date quit: Packs/Day: Years:

Drink alcohol?

☐ Yes ☐ No ☐ Past

If past, date quit:

Have you ever felt a need to cut down on your drinking?

☐ Yes ☐ No

45. Drink caffeine?

☐ Yes ☐ No ☐ Past

46. Type(s) and cup/s a day:

Coffee: Tea: Soda/Pop: Other:

47. Dietary Restrictions:

48. How many servings of fruits do you eat per day?

☐ Less than 1 ☐ 1-2 ☐ 3-4 ☐ 5 or more

49. How many servings of vegetables do you eat per day?

☐ Less than 1 ☐ 1-2 ☐ 3-4 ☐ 5 or more

50. Use pain medications daily?

☐ Yes ☐ No ☐ Past

Medication name:

51. Use recreational drugs?

☐ Yes ☐ No ☐ Past

52. Please list:

53. Are you Physically Active > 30 min/day:

☐ Yes ☐ No

54. If yes, how many times per week:

☐ 5 or more times per week ☐ 3-4 times per week

☐ 1-2 times per week ☐ Less than 1 time per week

55. Types of Exercise:

Family history

Family History

56. Do you have a family (parent, sibling or child) history of:

Condition	Yes	No	If yes, who?
Alzheimer's disease	☐	☐	
Heart Disease	☐	☐	
Stroke	☐	☐	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Cancer	☐	☐	
Bipolar Disease	☐	☐	
Depression	☐	☐	
Schizophrenia	☐	☐	
Attempted Suicide	☐	☐	
Substance Abuse	☐	☐	

If with Cancer/Mental Illness, please specify type:

Please have your photo ID and insurance card available at your appointment for our records.

GENERAL OFFICE POLICIES AND REGULATIONS

NEW PATIENT PAPERWORK AND AGREEMENT

I _____ declare I did not make any changes and have not edited in any way any of the documents received from The Institute for Advanced Psychiatry or downloaded from the website, except for signing and dating those documents

Date _____

PATIENT INTRODUCTION

Thank you for choosing the Institute for Advanced Psychiatry to help you with your healthcare needs. We look forward to getting to know you. Please read all of the information in the patient packet and let us know if you have any questions or require any assistance.

PATIENT INFORMATION

The more information we have regarding the patient, the better we are able to help. Therefore, it is important that the **New Patient Registration/Medical History** be completed as thoroughly as possible. This information may take time to complete so please make every effort to complete the forms prior to your appointment.

PROFESSIONAL SERVICES/BUSINESS POLICIES

Please be sure to read the **Privacy Policies, Consent for Treatment** and **Authorization to Release Information** carefully. These forms give details regarding our responsibilities to you as well as your agreement for proceeding with treatment. All relevant forms must be completed and signed prior to your appointment with the clinician.

Please submit your paperwork through your personal IntakeQ link at least 48 hours before your appointment.

We require you to confirm your appointment 48 hours in advance to ensure your plans have not changed.

This makes it much easier for us to have everything ready for you on the date of your appointment. Thank you, and we look forward to meeting you!

PRIVACY POLICIES

This notice describes how medical information about you may be used and disclosed and your access to it. Protected health information about you is obtained as a record of your visits or contacts with the providers and staff for healthcare services. Specifically, *PROTECTED HEALTH INFORMATION* is information about you, including demographic information (name, address, age, etc.) that may identify you and may relate to your past, present and/or future physical or mental health condition(s) and related healthcare services.

The Institute for Advanced Psychiatry is required to follow specific rules for maintaining the confidentiality of your protected health information, the use of your information and how this information is disclosed or shared to/with other healthcare professionals involved in your care and treatment. This Policy describes your rights to access and control your protected health information. It also describes how we follow those rules in the use and disclosure of your protected health information for the purposes of providing treatment, obtaining payment for the services you receive, managing our healthcare operations and for other purposes permitted/required by law.

YOUR RIGHTS UNDER THE PRIVACY RULE

The following is a statement of your rights under the Privacy Rule in reference to your protected health information. Please feel free to discuss any questions/concerns with the staff.

RIGHTS TO A COPY OF PRIVACY POLICIES

We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain. Upon request, you will be provided with a revised Notice of Privacy Policies.

YOUR RIGHTS TO AUTHORIZE OTHER USE AND DISCLOSURE

This means that you have the right to authorize or deny authorization for any other use/disclosure of protected health information not specified in this notice. You may revoke an authorization at any time except to the extent that a clinician or authorized practice staff has already taken action in reliance on the use or disclosure indicated in the authorization. Any revocation of authorization to use or disclose protected health information must be presented in writing.

YOUR RIGHTS TO DESIGNATE A PERSONAL REPRESENTATIVE

This means that you may designate a person who then has the delegated authority to consent to or authorize the use or disclosure of your protected health information. Any notice of revocation of authorization/designation of a previously named personal representative must be presented in writing.

YOUR RIGHTS TO YOUR PROTECTED HEALTH INFORMATION

This means that you may inspect and obtain a copy of protected health information about you that is contained in your patient record. Under certain circumstances, we may deny your request. Any requests for copies of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION

This means that you may request, in writing, that we not disclose any part of your protected health information for the purposes of treatment, payment for service you have received, or healthcare operations. You may also request that any part of your protected health information be restricted from disclosure to others who may be involved in your care or for notification purposes as described in this Notice of Privacy Policies. Under certain circumstances, we may deny your request for restriction. All requests for restriction of your protected health information must be made in writing.

YOUR RIGHTS TO REQUEST YOUR PROTECTED HEALTH INFORMATION AMENDED

This means that you may request an amendment of your protected health information for as long as we maintain the information. Under certain circumstances, we may deny your request for an amendment. All requests for amendment to your protected health information must be made in writing.

PRIVACY POLICY AUTHORIZATION

PLEASE INITIAL ALL STATEMENTS

You have certain rights regarding your protected health information under the Health Insurance Portability and Accountability Act (HIPPA). This document allows you to specify under what conditions your protected health information may be used or disclosed. HIPAA gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). Please initial what type(s) of information and for what purpose(s) you authorize us to disclose your protected health information.

_____ *The Institute for Advanced Psychiatry reserves the right to change notices and practices and that I will be given new notification, upon request, if this occurs. I understand that I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment or healthcare operations.*

_____ *The Institute for Advanced Psychiatry may release any/all medical information needed to my insurance company .*

_____ *I understand that I may revoke this consent in writing, except to the extent that the providers of the Institute for Advanced Psychiatry and support staff have already taken action in reliance thereon. I also understand that the provider designated for your care, and the support staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency*

The Institute for Advanced Psychiatry may release protected health information to HIPAA covered entities on my behalf. This includes, but is not limited to, health/insurance plans, other healthcare providers, healthcare claims clearinghouses and others.

_____ *I understand that I am also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to your office instead of your home. The Institute for Advanced Psychiatry staff may contact me in the ways specified below for general information (**Mark appropriate option**):*

Home ☐	Cell ☐	Work ☐	Personal ☐	Home. ☐	Cell ☐	Text ☐
Phone	**Phone**	**Phone**	**Email**	**VM**	**VM**	**Message**

The Institute for Advanced Psychiatry staff may communicate verbally and/or via email with others (including but not limited to family members who may answer the phone/check email) regarding appointments, test results and other general information.

List all approved persons who can receive information on your behalf:

Name and Cell_____

Name and Cell_____

Name and Cell_____

I understand this release may include records that contain information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to Medicare, Medicaid or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or the patient's employer. (The patient's employer will only be contacted if necessary to confirm enrollment in a healthcare plan).

_____*I consent to receive* ***appointment reminders*** *in the ways specified below*

(***Mark appropriate option***):

Cell ☐ *Phone* ☐

VM ☐ *SMS* ☐ *Email* ☐

_____***I consent to receive receipts in the ways specified below***

(***Mark appropriate option***):

Email ☐ *In-Person* ☐

_____*I consent to receive* ***Laboratory Requisite/ Reports*** *in the ways specified below*

Email☐ In Person ☐

My signature below signifies that I have read, understood and received a copy of the Notice of Privacy Policies. In addition, I understand that the above authorizations may be revoked at any time by written notice to the Institute for Advanced Psychiatry. Any revocation will become effective on the date it is received by the office of the Institute for Advanced Psychiatry. I understand that this authorization does not limit the treatments available to me; it only affects the use of my protected health information. I acknowledge and understand that uses and/or disclosures of my protected health information by HIPAA covered entities receiving information may occur and under these circumstances, I absolve the Institute for Advanced Psychiatry, its employed and independent contractor clinicians, and authorized practice staff of any responsibility and/or liability for such use and/or disclosure.

GENERAL OFFICE POLICIES AND REGULATIONS

The following are the policies and regulations of this office and are followed without exception. Read them carefully. Initial each statement and sign below indicating that you have been made aware of them and that you agree to adhere to them. If you are a minor, parent or guardian signature is required.

PLEASE INITIAL ALL STATEMENTS

_____***CONSENT FOR TREATMENT*** *I, the undersigned, as the patient or on behalf of the patient do hereby consent to and authorize all diagnostic and therapeutic plan considered necessary or advised in the judgment of the physician . I understand that no guarantee or assurance has been made as to the results, which may be obtained.*

INDEPENDENT CONTRACTOR PHYSICIAN DISCLOSURE

I understand that Dr. Casey Green is a fully licensed, board-certified psychiatrist who provides services as an independent contractor and is not an employee of Dr. Diana Ghelber or the Institute for Advanced Psychiatry. Dr. Green exercises his own independent medical judgment in evaluating, diagnosing, and treating his patients.

Initials: _____

_____ ***APPOINTMENTS***

Our appointments are scheduled ***just*** *for you. We offer reminder messages as a courtesy. However, it is ultimately* ***your responsibility*** *to know your scheduled appointment time and to arrive on time*

In the event of an emergency, we will do our best to work you in. This may result in a wait, and we appreciate your patience and understandingIf . If you are running late, we may not be able to extend your visit, as we want to respect everyone's time. Occasionally, unexpected delays may also affect your provider. We truly appreciate your patience and understanding, and we will

always extend the same courtesy to you.

_____ ***CANCELLATIONS :***

To ensure we can offer the highest quality care and maintain a supportive therapeutic environment for all patients, we require a fee for missed appointments or cancellations made with less than **24 business hours' notice**. Your appointment time is reserved specifically for you, and without adequate notice we are unable to offer that time to another patient who may need it. If an appointment is missed, the cancellation fee will need to be settled before we can schedule your next visit or process medication refills. We appreciate your understanding, as this allows us to manage our schedule responsibly and maintain reliable access to care for everyone.

- *$100 fee for missed or late-cancelled follow-up appointments*
- *$100 fee for missed or late-cancelled initial evaluations, payable before rescheduling*

_____ ***REQUESTS FOR MEDICAL RECORDS*** *If you have an appointment with another provider or any other request that requires information, referrals and/or medical records , you must notify our office at least 7 business days prior to your appointment date. All information in your chart is strictly confidential and cannot be released to anyone without your written consent. Records can be transferred to another physician upon you written request. This usually takes up to thirty days and is done in the order in which their requests are received. Records transferred to any persons other than physicians, i.e., patients, lawyer, certain insurance companies, etc. are subject to a fee. The amount of this fee will depend on the volume of the record.*

_____ ***LETTERS/ ADDITIONAL PAPERWORK REQUESTS*** *The time taken to review and/or process patient paperwork (extensive medical records, reports, correspondence, chart notes, etc.) will be assessed a fee for the time spent on the paperwork. All letters to any person other than physicians will be subject to a fee starting from $80.00. Again, the exact amount will depend on the complexity of the document and time spent. by the provider Patients are expected to pay for all requested papers before they can be sent or picked up. An authorization to release healthcare records will be required before paperwork can be completed. Our office does not do paperwork regarding disability or court appointed paperwork.* ***Please allow 10 business days to complete any requested paperwork.***

_____ ***BILLING/ CLAIMS*** *The Institute for Advanced Psychiatry is NOT contracted with insurance companies, and we do not file claims for the services you receive. We will provide receipts containing procedure and diagnosis codes upon request. Receipts requested at the end of the year will incur a fee based on time spent.*

_____ ***PAYMENT POLICY/ FEE AGREEMENT***

The Institute for Advanced Psychiatry requires payment for services at the time they are rendered. If payment is not rendered at time of service you will not receive service. You will also be responsible for $100 fee. Payments may be made with cash, personal check or credit card. We do NOT take American Express. ***There will be a $50 additional fee for all returned checks.*** *If you have any questions regarding payment and services you need to address this at time of service or no refund will be given. No refund will be given for rendered services. Patients are expected to maintain a zero balance. Accounts need to remain current in order to maintain ongoing treatment. Our office does not send patients invoices, but statements are available after each procedure. Please feel free to inquire about your balance before your account becomes delinquent. The patient/guardian is responsible for court cost, legal fees, or agency fees, which may be incurred in the collection of the account.*

_____ *COURT FEES: If a deposition or opinion in court is required there is $750 per hour charge, with a minimum charge of $2500 which must be paid in advance. If a clinician is subpoenaed with less than 15 days' notice, an additional $2,500 charge applies. We require a phone call from the patient or lawyer to notify the office*

_____ ***PHONE CONFERENCES*** *Patients are charged for time spent consulting with the providers on the telephone or the time taken for the clinician to consult with other professionals regarding your treatment (with your permission). The fee charged depends of the length of the conference.*

_____ ***PATIENT RIGHTS*** *At any time, patients may question and/or refuse therapeutic or diagnostic procedures or methods, or gain whatever information they wish to know about the process and course of therapy. Patients are also assured confidentiality that is protected both ethically by the Institute and legally by Texas State Law. There are, however, important exceptions to confidentiality that are legally mandated. In general terms, these exceptions include the following: 1) The law requires notification of relevant others if it is judged that a patient has an intention to harm him/ herself or another individual. 2) The law obliges us to report any incident of suspected child abuse, neglect or molestation in order to protect the children involved. Confidentiality will be respected in all cases, except as noted above.*

_____ ***DEPENDENT PATIENTS*** *If you are requesting our services as the parent/guardian of a child under the age of 18 or as the guardian of a dependent adult, the same general practice as outlined above will apply. However, as the child or dependent adult's psychiatric care provider, it is important that the patient be able to trust the physician/technician. As such, the physician/technician will keep the content of the patient's sessions confidential in the same way that she would keep confidential the content of an independent adult patient's sessions. This is not only the clinic policy, but also a state and federal law. This is true even when the parent/guardian is financially responsible for the patient's appointments. In general, specific information that the patient provides will not be released, however it is appropriate to discuss with the parent/guardian, the patient's progress and the parent/guardian participation in their treatment and any issues that represent imminent safety concerns.*

_____ ***MESSAGES*** *The Institute for Advanced Psychiatry has regular business hours Monday- Thursday 8am-4pm and Friday 8am-3pm During this time, messages may be left for clinician with any of the office staff.*

At any time:

-FOR LIFE THREATENING EMERGENCIES YOU MUST CALL 911 OR PROCEED TO YOUR NEAREST EMERGENCY ROOM.

THESE SITUATIONS SHOULD NOT BE HANDLED BY LEAVING A VOICEMAIL, EMAIL, PATIENT PORTAL OR A MESSAGE FOR THE DOCTOR.

For URGENT MATTERS, which cannot wait until the next business day, you may call the office phone at 817.659.7344 and leave a voicemail or call the doctor on call. If you need to speak with a clinician Monday-Thursday after normal business hours, you may call the office and dial 8. A fee of $75 will be assessed. On the weekends, you may contact the doctor on call whose contact information will be on the office line voicemail message. For all other matters, please call the clinic during normal business hours. Often, one of the office staff can handle your question and they will be pleased to assist you. Although your message is very important to us, please know that leaving multiple messages or emails will not speed up the process to receive a returned call. We check voicemails and emails periodically throughout the day and will contact you at our earliest convenience or, at the most, by the end of the business day.

Our clinicians do not discuss medication questions, psychotherapy issues, or personal matters via email. These matters are best discussed in an appointment . Any emails you send to clinicians may be read by office staff, so email communication should only be used for scheduling purposes.

_____ *MEDICATION REFILLS/ AFTER HOUR No routine prescriptions will be refilled after hours or on the weekends. Check your medications regularly and make sure that you have enough. Please allow 72 hours for prescription refill request to be processed. All requests received after 4pm on Thursday may not be processed until Monday. If you miss your appointment or run out of medication because you did not schedule a timely follow-up appointment as agreed upon in the previous appointment, prescriptions will, in general, not be refilled until you have a scheduled appointment. No refills will be allowed after repeated cancelations or if not clinically appropriately . Due to administrative requirements on issuing CII prescriptions a fee of 25 dollars will be implemented for requested between office visits. If you are prescribed Suboxone by a clinician, you are required to follow the drug screening protocol that has been discussed with you. If you fail to follow protocol medication will not be dispensed. Be sure to notify your provider if you are pregnant or think you may be pregnant. If you become pregnant while taking psychiatric medication(s), you will need to discuss the risks and benefits of the particular treatment(s) you are on with the clinician. In the case of an emergency please follow the protocol listed above.*

_____ ***COURTESY*** *We believe that it is important to make everyone as comfortable as possible when visiting the Institute for Advanced Psychiatry. We ask that you put any mobile devices on silent and refrain from using them during your session. Should you need to take or make a telephone call while waiting, please step outside to avoid disturbing others. In addition, we try to create an environment of courtesy and respect for patients, physicians and staff. Please remember to be courteous to everyone while present in the clinic. Rude or disruptive behavior could result in termination of the physician-patient relationship. Every effort is made to begin appointments on time, but sometimes it may be necessary to wait. We appreciate your patience and understanding.*

_____ ***TERMINATION*** *At times, terminating the physician-patient relationship is necessary. Termination of psychiatric treatment may occur at any time and may be initiated by either the patient or the doctor. Reasons for termination by the physician are generally due to patient non- compliance with treatment(s), missed appointments, multiple cancellations, or, in rare cases, the inability to continue a therapeutic relationship. The Institute for Advanced Psychiatry will continue to provide your care for 30 days after a notice of termination in order to allow you to find a new physician.*

_____ ***INACTIVE STATUS*** *The patient will only be considered an active patient if the patient keeps each appointment made or makes an alternative appointment with the office. After the passage of six months without an appointment the patient will automatically be considered an inactive .*

Inactive status may be instituted if bills are not paid in a timely fashion. Inactive status may be institute after two appointments missed with less than 24 hour cancellation notice.

Inactive status designates that The Institute for Advanced Psychiatry will reserve the right to direct triage to another provider or facility if the need arises. Only emergency triage will be provided. If the doctor has prescribed medication continuously and inactive status starts, a maximum of one month of medication may be prescribed while the patient finds an alternative health care provider. If the doctor decided to reinstate you as an active patient, a new patient appointment will be required.

_____ ***Telemedicine*** *services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites. 1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit. 2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room. 3.I attest that I understand that I* ***have to be physically in Texas for my appointment*** *and I will comply with this requirement 4. I understand that there are potential risks to using technology, including service interruptions,*

interception, and technical difficulties. a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit. 5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services. 6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes. a. I understand that my insurance carrier will have access to my medical records for quality review/audit. b. I understand that I will be responsible for any out-of-pocket costs that apply to my telemedicine visit. c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits. 7. I understand that this document will become a part of my medical record. By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language

VIDEO RECORDING:

Our offices use video cameras in the waiting room, hallway, and procedure rooms for the safety and security of patients, visitors, and staff. Video/audio may incidentally capture information that could identify you and/or relate to your care. Access to recordings is restricted to authorized personnel and vendors who support our systems and are obligated to protect confidentiality according to HIPAA law.

Recordings are not part of your designated medical record; however, they may be reviewed and used for health care operations such as safety/security incident review, quality assessment, and responding to emergencies, and may be used or disclosed as permitted or required by law (for example, to address a serious and imminent threat, comply with legal process, or cooperate with law enforcement when applicable).

We trust that you understand the necessity for these terms, and we thank you for your cooperation. If you have any questions, do not hesitate to ask the staff or the doctor.

Please sign below, acknowledging that you have received the above information and agree to abide by the terms hereof.

MY SIGNATURE BELOW CERTIFIES THAT I HAVE READ AND UNDERSTOOD THE ABOVE STATED GENERAL OFFICE POLICIES AND REGULATIONS OF THE INSTITUTE FOR ADVANCED PSYCHIATRY.

Signature _____ Date _____

_____ _____

Client Signature Date

MEDICARE PRIVATE CONTRACT

This contract is entered into this date __/__/____ by Name _____

and between Dr Diana Ghelber, MD (hereinafter called "physician"), and/or

AUDRA COSTON , NP (hereinafter called " nurse practitioner Audra Coston), and/or KAI CRAVEY, NP (hereinafter called " nurse practitioner KAI CRAVEY") whose principal medical office is located at 6800 Harris Parkway suite 100 and suite 100B FW, Tx (hereinafter called "beneficiary"), and shall become effective on this November 7th, 2019

Physician/ NP Obligations

The Physician has informed the Patient that Physician has opted out of the Medicare program effective on November 1 for a period of at least two years. Physician acknowledges that she is not excluded from Medicare part B under sections 1128, 1156, 1892 or any other section of the Social Security Act.

The nurse practitioner Audra Coston has informed Patient that nurse practitioner has opted out of the Medicare program effective on DECEMBER 18, 2024 for a period of at least two years. NURSE PRACTITIONER AUDRA COSTON acknowledges that she is not excluded from Medicare part B under sections 1128, 1156, 1892 or any other section of the Social Security Act

The nurse practitioner KAI CRAVEY has informed Patient that nurse practitioner has opted out of the Medicare program effective on October 24, 2025 for a period of at least two years. NURSE PRACTITIONER KAY CRAVEY acknowledges that he is not excluded from Medicare part B under sections 1128, 1156, 1892 or any other section of the Social Security Act

The physician / nurse practitioner acknowledges that this contract shall not be entered into with the beneficiary, or the beneficiary's legal representative, during a time when the beneficiary requires emergency care services or urgent care services, except that the physician/ nurse practitioner may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The physician/nurse practitioner acknowledges that he/she must retain this contract (with original signatures of both parties to this contract) for the duration of the

opt-out period, and that it shall be made available to the Centers for Medicare and Medicaid Services (CMS) upon request.

The physician/nurse practitioner shall provide a copy of this contract to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

The physician/nurse practitioner acknowledges that he/she must enter into a contract for each opt-out period

Beneficiary Obligations

The beneficiary, or his or her legal representative, accepts full responsibility for payment of the physician's charge for all services furnished by the physician.

The beneficiary, or his or her legal representative, understands that no payment will be provided by Medicare for items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

The beneficiary, or his or her legal representative, understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

The beneficiary, or his or her legal representative, agrees not to submit a claim, nor ask the physician to submit a claim, to Medicare for Medicare items or services, even if such items or services are otherwise covered by Medicare.

The beneficiary acknowledges that this written private contract contains sufficiently large print to ensure that the beneficiary is able to read this contract.

The beneficiary, or his or her legal representative, has entered into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare and for whom payment would be made by Medicare for their covered services, and that the beneficiary has not been compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.

The beneficiary, or his or her legal representative, understands that Medigap plans do not, and other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

The beneficiary, or his or her legal representative, understands that this agreement shall not be entered into with the physician during a time when the beneficiary requires emergency care services or urgent care services, except that the physician may furnish emergency or urgent care services to a Medicare beneficiary in accordance with 42 C.F.R. § 405.440.

The beneficiary, or his or her legal representative, acknowledges that a copy of this contract has been provided to the beneficiary, or to his or her legal representative, before items or services have been furnished to the beneficiary under the terms of this contract.

Date ___/___/_____

Name of Beneficiary (printed) or His/Her Legal Representative

_____ SIGNATURE _____

Agreement for Control Substance Treatment

This agreement has been developed in the interest of promoting optimal drug therapy while minimizing risks to the patient. Your compliance is appreciated

I, agree that Dr. Diana Ghelber/or another appropriate provider designated for your care will be the only clinician prescribing medication for ***benzodiazepines or ADHD medication***

1. I understand the importance of taking the medication at the dose and frequency prescribed by my physician.

2. I will attend all reasonable appointments, treatments and consultations as requested by my physician.

3. Refills:

- Controlled substance prescriptions are highly regulated and followed by the State of Texas. ***Due to administrative requirements on issuing controlled substance prescriptions, a fee of 25 dollars will be implemented for requests between office visits.***

- The medication will ***not*** *be refilled after hours and on weekends.*

Check your medication regularly. Make sure that you have enough. ***Allow 72 hours for the refill*** *to be processed. Requests received* ***Friday after 12.00 pm*** *may not be processed until Monday.*

- It is the responsibility of the patient to ensure the correct pharmacy is on file. It is the responsibility of the patient to ensure pharmacy on file has adequate stock of medication

- Be aware that stopping Benzodiazepines abruptly in certain doses, has been associated with risk of seizures. You will need to present to the Emergency Room to have the prescription renewed until our clinic is during regular business hours.

4. ***Benzodiazepines can not be prescribed with opiates*** *due to risk of respiratory depression and death. Please update all your providers of any change in your medication.*

5. You must agree that ***early refills will not be given****. The prescribing physician may require* ***random urine testing*** *as a matter of routine monitoring.*

6. I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my Benzodiazepines/stimulant therapy. I acknowledge that my physician is not obligated to replace any medication shortfall.

7. I agree that ***medications will not be replaced*** *if they are lost, flushed down the toilet, destroyed, left on an airplane, etc.*

If your medication has been stolen, you will need complete a police report regarding the theft and present that report to the prescribing physician.

8. I understand that is ***illegal to share , sell my medication, to use someone else medication, or to use multiple prescribers for my medication***

I understand that if I break this agreement, my physician reserves the right to stop prescribing controlled substances for me and may consider termination of the therapeutic relationship.

Date: __/___/_____

Patient Name _____ Signature_____

Twofold Health - Patient Consent Form

(Transcription software)

General Notice
I have a legal and ethical responsibility to make my best efforts to protect all communications that are part of our sessions. I have chosen to use Twofold Health's AI transcription tool to provide the best care to my clients. This tool provides an automatically generated summarization of our sessions. Twofold Health's system is HIPAA compliant and uses up-to-date encryption methods, and multiple layers of security and privacy technology to keep your information private and secure. By signing this form, you consent to our sessions being processed using Twofold Health's system.
Details

1. Data Collection and Use

- Transcription and Summarization: Recordings of our sessions will be transcribed and summarized by Twofold Health's HIPAA-compliant technology. Twofold Health does not store the recordings.
- Retention of Summarized Notes: I may choose to keep the summarized notes as part of your confidential medical record.
- Anonymized Data: Twofold Health only keeps anonymized data to help improve the tool. As with any technology, there are certain risks and benefits, which are listed below:

2. Risks and Mitigations

- Confidentiality: All technology carries a risk of confidential information being disclosed. Twofold Health mitigates this risk by ensuring up-to-date technological security and storing the data with minimal identifying information.
- Bias in Summarization: The system may contain unknown biases in the way it generates the session summary and presents clinical information. This risk is mitigated by my commitment to review and modify the notes as needed using my clinical expertise.
- Twofold Health researchers will have access to your de-personalized transcripts (with names, emails, and other identifying information removed) solely for the purpose of improving the product and for specific customer support inquiries, when requested.

3. Benefits

- Focus on Care: The technology allows me to focus more on care.
- Reduction in Administrative Workload: Removes the need for taking notes during the session, reducing the administrative workload and potentially helping with compassion fatigue.
- Improved Clinical Insights: The technology may provide additional clinical insights, helping to improve outcomes in the care process.

Consent
By signing this consent form, you agree to allow me to use the Twofold Health software to transcribe and summarize our sessions.

Client Name: _____Date: __/___/_____

Signature: _____