Dr. Cherri E. Penton, PhD, MP
Medical Psychologist Advanced Practice

Appointments: (225) 387-2287 **Fax: (225) 755-2573**

PATIENT AGREEMENT

This document contains important information about my professional services and policies. Please take a few minutes to review the following information and ask me any questions you may have.

PROFESSIONAL FEES

My fees for medical psychology and psychology services are shown in the Fee Schedule which is included as a part of this Patient Agreement. In addition to therapy session appointments, I charge $250/hour for other professional services the patient may need, though I will break down the hourly cost if I work for periods of less than one hour. Other services include, but are not limited to, report writing, telephone conversations lasting longer than 5 minutes, consulting with other professionals with your permission, preparation of records or treatment summaries, and the time spent performing any other services you may request of me. As a rule, I do not get involved in legal proceedings; however, if you become involved in legal proceedings that require my participation by summons, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. (Because of the complexities of legal involvement, I charge $500.00 per hour for preparation of materials and attendance at any legal proceeding.). Please note, the rates in the Fee Schedule are subject to change without prior notification.

CANCELLATION POLICY

As scheduled appointment times are reserved especially for you, all appointments are subject to charge, whether missed or cancelled, if there has not been **1 business days notice given.** In order to avoid being charged for the missed appointment, you must call by 5:00 p.m. at least 1 business day prior to your appointment day, unless we both agree that cancelling with less than 1 business day notice was caused for reasons beyond your control. Insurance companies and Medicaid **do not** pay for missed appointment charges; therefore these charges will be your responsibility. **Two "no show" appointments could result in treatment ending for non-compliance and referral back to your physician and insurance company for reassignment to another provider.**

INSURANCE ACCEPTANCE AND VERIFICATION

At present, I am an in-network provider for all commercial Aetna plans, Assurant Health, Blue Cross Blue Shield, Cigna, Humana, PPO Plus, all commercial United Health Care plans, and Web TPA. If you are insured by one of these private insurance plans, it is your responsibility to verify your coverage includes mental health benefits and to obtain any pre-authorization your plan may require for mental health services to be provided under your plan benefits. *PLEASE NOTE: I DO NOT ACCEPT EAP REFERRALS OR MEDICAID PLANS*. If you have not obtained pre-authorization for mental health services your plan requires, you are responsible for payment in full at the time of service. If you have obtained any required pre-authorization for mental health services from one of the above carriers, the Business Office will file the insurance claim for you; however, you are responsible for whatever co-payment, coinsurance and deductible your plan requires payable at the time of your appointment or after billing. *Please note, the information you receive from your insurance carrier is not a guarantee of payment and your insurance company may or may not pay for services.* Once charges are submitted, the insurance company may determine benefits differently than they initially indicated. Should this occur, you are responsible for paying any difference in fees not covered by insurance.

_____ _____

Initial Date

If you are covered by an insurance carrier that Dr. Penton is not an in-network provider, you may be entitled to any out-of-network insurance reimbursement your plan allows. In this case, you are responsible for full payment of my fees at the time service is provided. The Business Office will provide you with appropriate documentation so that you can file a claim with your insurance carrier to reimburse you directly.

You should also be aware that your contract with your health insurance company requires that I provide it with information relevant to the services that I provide to you. I am required to provide a clinical diagnosis, and sometimes I am required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record to your insurance company.

PATIENTS WITH COMMERCIAL INSURANCE AND MEDICAID

If you have both commercial health care insurance and secondary Medicaid coverage, you must provide information regarding only your commercial insurance plan as I do not file Medicaid claims. If you have private health care coverage, it is your responsibility to obtain any pre-authorization your plan requires. You are responsible for payment in full if appropriate pre-authorization has not been obtained.

RETURNED CHECKS

There will be a $30.00 service charge applied to your account for all returned checks or insufficient funds on your credit card if paying with a credit card. If paying by credit card, it is your responsibility to notify my Business Office of any changes in card number , expiration date and/or security code.

DELINQUENT ACCOUNTS

Should your account become 60 days delinquent, late payment fees may be applied, and your bill may be turned over for collections. Should this happen, you will be responsible for payment of all legal and collection fees.

LIMITS OF CONFIDENTIALITY STATEMENT

All information between practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self or others.
4. Child or Elder abuse and/or neglect is suspected.
5. Any official review of the services provided (if you have signed a release authorizing a review, such as insurance forms)

In the case of #3 and #4 above, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

CONTACTING ME AND EMERGENCY ACCESS

Due to my work schedule, I am often not immediately available by telephone. Office support personnel are generally available to answer the phone and take messages between 8 AM and 4:30 PM on weekdays. I will make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are unable to reach me and feel it is an emergency or feel that you can't wait for me to return your call, you should contact your family physician, call 911 or go to the nearest emergency room and ask for the psychologist, social worker, or psychiatrist on call. Prescription refill requests received after 5:00 PM on Friday will be sent on the following Monday morning.

_____ _____

Initial Date

CONSENT FOR TREATMENT

I authorize and request Dr. Cherri E. Penton to carry out psychological exams, treatment and/or diagnostic procedures which now, or during the course treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, Dr. Penton can make no guarantees about the outcome of the treatment. If Dr. Penton prescribes medication, I understand that it is my responsibility to ensure that the medication is taken only as prescribed, and it is my responsibility to alert Dr. Penton regarding all other prescription, herbal and over-the-counter medications currently being used.

PAYMENT RESPONSIBILITY

I understand that I am responsible for payment of all fees charged, and I agree to pay for all services rendered. If I have insurance which covers mental health benefits, for which Dr. Cherri E. Penton is a provider, and for which I have obtained any necessary preauthorization, I agree to make the co-payment or deductible stipulated by my health plan for services rendered **at the time of each visit**. I understand that Dr. Cherri E. Penton's office will submit any insurance claims for me to those insurance companies for which she is a provider and mental health services have been authorized. I understand that if my insurance company denies payment, does not reimburse Dr. Cherri E. Penton within 60 days for services rendered, or provides reimbursement differently than they originally indicated, I will be personally responsible for payment of any unpaid balance. I understand that it is my responsibility to pay late cancellation and "no-show" fees.

PATIENT/PARENT/GUARDIAN AGREEMENT

I authorize release of information to and from my Primary Care Physician, other health care providers, institutions and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my insurance health plan. I authorize payment of medical benefits to Dr. Cherri E. Penton for claims filed by Dr. Cherri E. Penton's office. I authorize the release of necessary information to a collection agency should that become necessary.

_____	_____
Patient Name: Printed	Parent/Guardian Name: Printed (if Patient a Minor)
_____	_____
Patient/Parent/Guardian Signature	Date

Cherri Penton, Ph.D., MP , MPAP
Revised : 01/01/2022

_____	_____
Initial	Date

PATIENT FEE SCHEDULE*
(PSYCHOTHERAPY/MEDICAL MANAGEMENT SERVICES)

CPT PROCEDURE CODE	PROCEDURE	FEE
90791	Initial diagnostic evaluation (w/o med mgt)	$250.00
90792	Initial diagnostic evaluation (w/ med mgt)	$275.00
99213	E/M service, 15-20 minutes	$100.00
99214	E/M services, 21-30 minutes	$150.00
99215	E/M services, 31-45 minutes	$200.00
90833/32	Psychotherapy 16-37 minutes add-on to E/M services	$100.00
90836/34	Psychotherapy 38-52 minutes add-on to E/M services	$150.00
90838/37	Psychotherapy 53-60 minutes add-on to E/M services	$200.00
90847	Family psychotherapy w/patient present, 45 minutes	$200.00
90846	Family Psychotherapy w/o the patient present, 45 minutes	$180.00
96130	ADHD Assessment w/o report	$750.00

Legal Proceedings: $500.00/hr

* Fees for out-of-network insurance and self pay patients. For in-network insurance patients, patient payment responsibility is based on insurance Explanation of Benefits**. If claim is denied, patient is responsible for payment in full. Insurance companies often do not approve Psychological and ADHD Testing. Patients are responsible for minimum payment of $100.00 for all missed appointments (appointments not cancelled one business day in advance of the appointment date and time unless due to illness or emergency).**

Fee schedule is subject to change without notice.

Effective 01-October-2022

Initial _____ Date _____

PATIENT INFORMATION **Date:**_____

Please print legibly (circle answers or fill in blanks). Please complete all of this form.

Patient: _____ _____ ___
Last **First** **MI**

Address: _____
Street/Apt. #

_____
City **State** **Zip**

Home#(____)_____**Cell#(_____)**_____

Work#(____)_____

Date of Birth_____ **Age**_____

Sex: M F

Social Security # _____

Marital Status: Single Married Separated Widowed Divorced

School Name: _____**Grade** _____

Emergency Contact:_____

Tel: _____

Reason for Appointment: _____
_____
_____

If Patient a Minor:

Parent/Guardian _____ _____
Last **Last**

Relation: Biological Parent Custodial Parent Guardian

Home#(_____) _____**Cell#(____)** _____

Work#(_____)_____**SS#** _____

Parent/Guardian 2 _____ _____
Last **First**

Relation: Biological Parent Custodial Parent Guardian

Home#(____)_____ **Cell#(____)**_____

Work#(____)_____**S/S #**_____

Address to send Statements: _____

_____

_____

e-mail: _____

I understand that I am responsible for payment of all copays, coinsurance and deductibles and payment in full for all claims not paid by insurance.

_____
Signature

_____
Date signed

Primary Care Physician/Pediatrician

MD Name:_____

Clinic Name: _____

Street: _____
City, State, Zip: _____
Office# (_____)_____ **Fax#** (____)_____

Prescriptions, herbal/diet supplements, over-the-counter medications (name and dosage):

_____

_____

_____
_____
_____

_____
Initial

_____
Date

INSURANCE INFORMATION FORM

Please note that as a healthcare provider my relationship is with you, not with your insurance company. Your health insurance is a contract between you, your employer and the insurance company.

If you have mental health insurance benefits my Business Office will bill insurance on your behalf, but we ask that you help us bill correctly by giving complete and accurate information. Please complete Section A, then it is imperative that YOU CALL YOUR INSURANCE COMPANY to complete Section B since information on your insurance card may not apply to your mental health benefits. In some cases, mental health benefits have been carved-out to a third party insurer. We have found that many patients find this form helpful in determining what their mental health benefits actually are, even if your insurance is with a company for which I am not an in-network provider.

SECTION A: All patients need to complete

Patient Name:_____ _____ __
Last First MI

Insured Name:_____ _____ ___
Last First MI

Patient's Social Security #: _____

Insured Social Security #: _____

Patient's Date of Birth: _____)_____

Insured Date of Birth: _____

Insured Address:_____
(if different from patient address entered on Patient Information)

HEALTH INSURANCE: The following information can be found on your insurance card (if self pay, indicate on Insurance Co, line)

Insurance Co.:_____ **Subscriber #**: _____
(May be listed as Insured SS #, Policy #, Member #, or ID #

Member Services Phone # (_____) _____ **Group #:** _____

Mental Health Phone # (_____) _____ **Employer:** _____

SECTION B: IF YOU HAVE COMMERCIAL INSURANCE, YOU MUST CONTACT YOUR INSURANCE COMPANY AND COMPLETE THE INFORMATION BELOW. FAILURE TO CALL YOUR INSURANCE COMPANY TO COMPETE SECTION B OFTHIS FORM WILL RESULT IN YOUR HAVING TO PAY IN FULL AT THE TIME OF SERVICE.

Insurance Co. Phone # (____) _____ **Date:** _____**Person spoken to:**_____
What is the name and phone # of the insurance division or company that handles my mental health benefits? _____
_____ **Phone:** (____) _____**Person spoken to:** _____
Is Cherri E. Penton, Ph.D. MP a provider in my network? Yes No Is prior authorization required for outpatient psychotherapy and medical management? Yes No If yes, please obtain authorization for psychotherapy and medical management appointments for a 12 month period. If prior authorization is required and not obtained, you are responsible for payment in full for all services provided.

_____ _____ _____
Authorization Number Dates Valid Number of sessions and CPT Codes Authorized

_____ _____ _____
Authorization Number Dates Valid Number of sessions and CPT Codes Authorized

What is the effective date of the insurance coverage? _____ **What is my Mental Health Plan Member #?** _____
(often different from above ins. #)

What date do benefits begin again? _____ How many mental health visits are allowed/year? _____

Do I have any annual or lifetime maximum coverage limit for mental health? _____

What is the deductible? _____ How much have I met to date? _____

What is my in-network Mental Health Co-pay or out-of-network Percent Covered by Insurance? $_____ or _____
Co-Pay ($ amount) Percent amount

What is billing address/tel. for **mental health claims**:_____

_____

_____ _____
Initial Date

Dr. Cherri E. Penton, PhD, MP
Medical Psychologist Advanced Practice

Child/Patient Family History

Child/Patient Name: _____

Child/Patient Date of Birth: _____

Pease list the main concern(s) you have regarding your child

Please check the boxes that may apply to your child and other family members

Problems with:	Child/Patient	Child's/Patient's Mother	Child's/Patient's Father	Child's/Patient's Siblings	Child's/Patient's Extended Family
Hyperactivity and/or impulsivity					
Attention					
Learning at school					
Anxiety					
Depression					
Motor or vocal tics					
Psychosis or schizophrenia					
Suicide					
Compulsive behavior					
Oppositional behavior					
Mental retardation					
Alcohol					
Marijuana					
Other drugs					
Sexual abuse					
Hospitalized for emotional issues					
Heart problems					
Seizures					
Other (please specify:					

_____ _____

Initial Date

Cherri E. Penton, PhD, MP
Medical Psychologist Advanced Practice

We offer helpful administrative information by regular text messaging and e-mailing such as appointment reminders and responses to text messages and e-mail messages you may send to me. There is some level of risk that information in a regular text message or e-mail could be read by someone besides you. Please let us know if you would like us to communicate with you by text message or e-mail.

☐ Yes – Please communicate with me by e-mail. My e-mail address is

☐ No- Please do not communicate with me by regular (unencrypted) e-mail

☐ Yes – Please communicate with me by text message. My cell number is

☐ No - Please do not communicate with me by text message

Please note, if you select No for both means of communication, we will not be able to respond to any e-mail or text message you send us. In this case, we will only respond to messages sent via Dr. Penton's Patient Portal.
Patient's Name: _____
Patient's Date of Birth: _____
Patient/Parent Signature: _____

Cherri E. Penton, Ph.D., MP. MPAP

_____ _____
Initial Date

Cherri E. Penton, Ph.D., MP, MPAP

Telemedicine/Teletherapy Authorization Form

Telemedicine/Teletherapy

Cherri E. Penton, Ph.D., MP. MPAP is hereby authorized to provide therapy, medication management and consultation services with me/my child via Telemedicine/Teletherapy. Telemedicine/Teletherapy is a form of psychological service provided via internet technology, which can include consultation, treatment, transfer of medical data, emails, telephone conversations and/or education using interactive audio, video, or data communications. I also understand that telemedicine/teletherapy involves the communication of my medical/mental health information, both orally and/or visually. Telemedicine/Teletherapy has the same purpose or intention as psychotherapy or medical psychological treatment sessions that are conducted in person. However, due to the nature of the technology used, I/my child understand that telemedicine/teletherapy may be experienced somewhat differently than face-to-face sessions.

I/my child understand that I/my child have the following rights with respect to telemedicine/teletherapy:

Patient's Rights, Risks, and Responsibilities:

1. I have the right to withhold or withdraw consent for telemedicine/teletherapy for me/my child at any time without affecting my/my child's right to future care or treatment.

2. The laws that protect the confidentiality of my/my child's medical information also apply to telemedicine/teletherapy. As such, I understand that the information disclosed by me/my child during the course of my therapy or consultation is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, which are described in the general Consent Form I/my child received at the start of my treatment with Cherri E. Penton, Ph.D, MP, MPAP.

3. I understand that there are risks and consequences of participating in telemedicine/teletherapy, including, but not limited to, the possibility, despite best efforts to ensure high encryption and secure technology on the part of my medical psychologist, that: the transmission of my information could be disrupted or distorted by technical failures; the transmission of my information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

4. There is a risk that services could be disrupted or distorted by unforeseen technical problems.

5. In addition, I/my child understand that telemedicine/teletherapy based services and care may not be as complete as face-to-face services. I/my child also understand that if the medical psychologist believes I/my child would be better served by another form of therapeutic services (e.g. face-to-face services) arrangements will be made to arrange face-to-face services

6. I understand that I/my child may benefit from telemedicine/teletherapy, but that results cannot be guaranteed or assured. I/my child understand that there are potential risks and benefits associated with any form of psychotherapy, and that despite my efforts and the efforts of my medical psychologist, my/my child's condition may not improve, and in some cases may even get worse.

7. I/my child accept that telemedicine/teletherapy does not provide emergency services. If I/my child are experiencing an emergency situation, I/my child understand that I can call 911 or proceed to the nearest hospital emergency room for help. If I/my child are having suicidal thoughts or making plans to harm myself or others, I/my child can call the National Suicide Prevention Lifeline at 1.800.273.TALK (8255) for free 24 hour hotline support. Patients who are actively at risk of harm to self or others are not suitable for telemedicine/teletherapy services. If this is the case or becomes the case in future, my medical psychologist will recommend more appropriate services.

8. I/my child understand that there is a risk of being overheard by anyone near me if I/my child am not in a private room while participating in telemedicine/teletherapy. I/my child am responsible for (1) providing the necessary computer, telecommunications equipment and internet access for my telemedicine/teletherapy sessions, and (2) arranging a location with sufficient lighting and privacy that is free from distractions or intrusions for my/my child's telemedicine/teletherapy session. It is the responsibility of the medical psychologist provider to do the same on their end.

_____ _____

Initial Date

Cherri E. Penton, Ph.D., MP, MPAP

Telemedicine/Teletherapy Authorization Form

9. I/my child understand that dissemination of any personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without my written consent.

Insurance and charges

I/my child hereby authorize Cherri E. Penton, Ph.D, MP, MPAP to furnish information, including diagnoses, Progress Notes and Medication Logs to insurance carriers and doctor's offices concerning my/my child's telemedicine/telehealth services as well as conventional office visits. I understand that I am responsible for all fees associated with telemedicine/teletherapy services as well as services provided in conventional office visits for me/my child, and that if my insurance provider has not paid claims submitted by Cherri E. Penton, Ph.D., MP, MPAP within sixty (60) days of filing a claim, I am responsible for payment in full for the services provided. I will also be responsible for any copayment or deductibles that may apply as well as legal or other costs incurred in the collection on my/my child's account.

Cancellation Policy

As scheduled telemedicine/teletherapy appointment times are reserved especially for you, all telemedicine/telehealth appointments are subject to charge, whether missed or cancelled, if there has not been **1 business days notice given.**

Release of Medical/Psychological Information

Cherri E. Penton, Ph.D., MP, MPAP is hereby authorized to release information relative to my/my child's medical and psychological condition to my/my child's insurance company, physicians, medical facilities or local, state or federal agencies which may potentially offer me/my child assistance.

Obtaining Medical/Psychological Information

I hereby authorize my/my child's physicians to furnish Cherri E. Penton, Ph.D., MP, MPAP any and all information requested by Cherri E. Penton, Ph.D., MP. MPAP concerning me/my child in connection with any illness, condition, or injury, including medical and psychological history, consultations, prescriptions, treatment, and/or copies of any and all hospital or medical records which you have pertaining to me/my child. A photo static copy of this authorization shall be considered as effective and valid as the original. This authorization is valid until revoked by me in writing.

Patient Name: Printed	Parent/Guardian Name: Printed (if Patient a Minor)
Patient/Parent/Guardian Signature	Date

Cherri E. Penton, Ph.D., MP, MPAP
04/01/2020

Initials: _____ Date: _____