NPBTC
Neurology, Psychiatry and Balance Therapy Center, LLC

NPBTC Office Policies and Information

Thank you for choosing Neurology, Psychiatry and Balance Therapy Center (NBPTC) and welcome to our office. Here is some information that will familiarize you with how we serve our patients.

Office Hours: Monday: 8:00 am– 5:00 pm Tuesday: 9:00 am – 7:00 pm Wednesday: 8:00 am – 6:00 pm Thursday: 8:00 am – 7:00 pm Friday: 9:00 am – 4:00 pm Saturday and Sunday: Closed	Fee Summary*: No show/cancel ..... $35-50 ** Copy of health record..... $1/pg. ($25max) Writing a letter ..... $25 Filling out a form..... $25 Letter and form..... $50
Phone Session Fee Summary*: 0:00-6:00 min .....$15 6:01-12:00 min .....$30 12:01-18:00 min .....$45 18:01-24:00 min .....$60 24:01-30:00 min $75	Phone Session Fee Summary*: 30:01-36:00 min .....$90 36:01-42:00 min .....$105 42:01-48:00 min .....$120 48:01-54:00 min .....$135 54:01-60:00 min $150
Portal Communication- Cumulative time spent 5-10 minutes.....$15 11-20 minutes.....$30 21+ minutes.....$50	Imaging Reviews.....$15

*Fees subject to change without notice

**Pricing dependent on appt length, see below

1. Scheduling and Appointments
    a. We strive to see patients at their designated appointment times. Please arrive on time for your appointment so we can give you your full appointment duration and we won't have to delay other patients after you. Also, during your appointment, please try to stick to the allotted appointment duration for the same reason.
        a. Grace Periods: Given the time constraints, we offer no grace period for 15 minute appointments. You must be on time. We allow a 10 minute grace period for a 30 minute appointment and 15 minutes for a 45 or 60 minute appointment however your appointment will be shortened to fit in your allotted time. If you are outside of these windows, you will have to be rescheduled and charged a no-show fee.
    b. NO SHOW/LATE CANCEL
        a. We ask that you please give us at least 24 hours' notice if you have to cancel or change your appointment.

   b. This includes missing sessions in case of emergencies or illness. This is a practice business necessity and not a punitive fee.
   c. Reminder calls, texts, and emails through our automated system are a courtesy and may not occur at all times.
   d. Fee's are based on duration of scheduled appointment as follows:
      i. 15 minute appt late cancel will be charged $35
      ii. 30, 45 or 60 minutes appt late cancel will be charged $50

c. If you no-show or cancel without 24 hours' notice, it will be your responsibility to contact the office to reschedule at next available opening for provider, please keep in mind this may not be for a few months out
d. If you have two or more no-shows or cancellations without 24 hours' notice consecutively for scheduled appointments, you will be removed from the schedule. You may then be terminated from care.
e. If a provider requests an appointment prior to medication refill, you will have 90 days to schedule this requested appointment. Medications will be filled during this 90 day period. After 90 days, you will become an "inactive" patient, no further prescriptions can be refilled and you will need to be seen as a "new patient" to resume care.
f. To remain an active patient of our office, patients need a minimum of one annual in office appointment for either psychiatry or neurology.
   a. Psychiatry patients need a 45 minute annual appointment
   b. Neurology patients need a 30 minute annual appointment
g. Appointment Types and Reminders:
   a. If you are doing a virtual appointment, you must be in the state of Pennsylvania at the time of the appointment. If you are not, appointment will be cancelled and you will be charged a no-show fee.
   b. All patients being prescribed medications from this office are required to do at least one appointment in person annually and it is the patients' responsibility to ensure this is scheduled. Failure could lead to delay in medication refills
   c. If you request a phone session, it is your responsibility to know if it is a service covered by your insurance. If it is not, it is your responsibility to pay for the visit
h. Portal messaging:
   a. Many insurances cover portal messaging. Please check with your insurance company to see if this is a service covered under your plan.
   b. If this service is not covered by your insurance, you will be responsible for the portal message charges listed at the top of page 1.

2. Financial Responsibility

a. Copays and other payments are due at the time of service. As a courtesy, we will attempt to verify your insurance benefits, but it is ultimately your responsibility to know your coverage. Verification of benefits is not a guarantee of payment. We bill your insurance company as a courtesy to you; provided that the insurance carrier is contracted with us. Your insurance benefits are a contract between you and your insurance company. It is your responsibility to verify your health benefits. If benefits are exhausted, you are liable for all charges incurred. Whatever disagreements you have with your insurance company including benefit information, it is your responsibility to contact your insurance company to resolve. It is our policy that we collect any amounts as verified through your insurance company, such as co-pays or deductibles. We will not make multiple verifications if you disagree with the information obtained from your insurance company. It is your responsibility to contact your insurance company if there are any discrepancies.
b. You are responsible for payment of the co-payment, deductible, coinsurance, and all amounts identified by the insurer as the patient's responsibility.
c. You are responsible to provide updated referrals and authorizations when required by your insurance carrier
d. You are responsible for all charges for services rendered if your insurance denies payment for any reason.
e. Please advise us of any changes of your insurance as soon as possible.
f. Please be aware that this office does not accept Medicaid insurance as a primary or secondary. If you are needing to go on Medicaid, inform the office immediately as we will unfortunately no longer be able to provide your care and will help with the transition and provide you with a list of providers who accept Medicaid
g. We will retrieve authorization for the initial services. It is your responsibility to request us to obtain additional authorizations after the initial authorization has lapsed and/or all visits authorized have been used. If you fail to notify us to retrieve authorization for the services and authorization is not obtained, any charges incurred that the insurance company denies due to lack of authorization will be your financial responsibility.
h. A $50 late fee will be charged for balances outstanding 30 days past the first statement date.

3. Medication Refills: We require a 3 business days notice for any prescription refill. We try to honor prescription refill requests within three business days from Monday through Friday. If you are going to run out of a medication that we prescribed, please call us well in advance so we have time to get your medication authorized and submitted and ensure you won't miss any of your doses. Please review your medications before calling our office to make sure you are only asking for a medication prescribed by us.

4. Administrative and Clinical Service Fees:
    a. Fees for administrative services listed in this section are to be paid in advance and are not billed to your insurance carrier.
    b. If you would like a copy of your medical record please fill out an Authorization for Release of Medical Information. The charge for a copy or your record is $1 per page up to a maximum of $25.
    c. If you need a letter written or have a form that needs to be filled out there is a $25 fee for each which must be paid in full before completion. It may take a minimum of two weeks for these documents to be completed. We do not fill out any type of paperwork unless you have been a patient with us for at least 6 months and have had at least 3 appointments
    d. If you wish to speak directly to a provider outside of an appointment, there will be a $30 charge if the call goes over 6 minutes and an additional $15 charge for the phone call for each additional 6 minutes after. Before talking directly to a provider, you must provide information of your active valid credit card that we will keep on file to charge for that call. We accept VISA, MasterCard, and Discover.

5. Termination Policy and Procedure
    a. You may terminate treatment at any time.
    b. NPBTC may terminate treatment for the following reasons:
        a. The provider determines that your clinical needs are beyond the scope or capability of services of the provider.
        b. You are failing to adhere to the treatment plan – i.e. misuse of prescribed medication, failure to notify the provider of significant changes in condition, two or more no-shows or cancellations without 24 hours' notice consecutively for scheduled appointments, or multiple appointment cancellations that result in significant periods without treatment.
        c. Failure to pay outstanding charges on your account including no show fees.
        d. Inappropriate behavior (e.g., threats, derogatory language, and/or not limited to any disruption to our office).
    c. If NPBTC terminates care, then you will be provided written notice including the reasons for the termination. Notice period will be 90 days UNLESS termination is due to non-adherence with the treatment plan or inappropriate behavior, in which case you will be considered to have violated our policies and waived the notice period.
    d. If your treatment has been terminated for any of the reasons listed above, then your record will not be re-opened in the future for any reason or for any other NPBTC provider, unless authorized by the Physician Owner

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6. Polices and Fees Subject to Change: The policies and fees outlined in the document are subject to change without notice.

I acknowledge that I have read and understand the above Policies and Information.

_____ _____
Signature of Patient, Parent or Legal Guardian Date Signed

_____ _____
Printed Name Relationship

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CONTROLLED MEDICATION CONTRACT

Patient's Name_____Date_____

Pharmacy_____ Phone Number_____

As a patient of **Neurology, Psychiatry and Balance Therapy Center**, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time for all of my scheduled appointments; to adhere to the payment policy outlines by this office. I agree to call at least 24-hours in advance if I must reschedule my appointment. I understand that a last minute reschedule (less than 24 hours notice) counts against me as a "No Show" appointment. I understand that I may be discharged from the office after three "No-Shows" in one year or two consecutive "No-Shows".
2. I understand that I must be seen physically in office at least once annually per DEA and office policy to continue to receive prescriptions for controlled substances. I understand it is my responsibility to schedule my in-person appointments and if I have not been seen in over a year, I understand my prescriptions may not be able to be refilled
3. I agree to conduct myself in a courteous manner in the doctor's office. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree to only use primarily one pharmacy for my controlled medications. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my medication is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
6. I agree that my prescription can only be given to me at my regular office visit. A missed visit may result in my not being able to get my prescription until next visit.
7. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost/stolen medication will not be replaced for any reason. I agree not to obtain other controlled medications from any other medical providers, pharmacies, or other sources.
8. I understand that if I am going to a methadone or buprenorphine (Suboxone or Subutex) day clinic, I will need to bring documentation to every appointment. The documentation must include the provider's name/credentials (MD, DO, PA-C, or NP), name of medication, medication dose, and appointment time/date.
9. I understand that mixing controlled medications or alcohol can be dangerous. I recognize that several deaths have occurred among persons mixing benzodiazepine and opioid pain medications (especially if taken outside the care of a medical provider or in higher than recommended doses). I agree to sign a release form if I am going to a pain management office.
10. I agree to take the medication as my medical provider has instructed and not to alter the way I take the medication without first consulting my provider.

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11. I recognize that my mental health is important and medication management alone is not sufficient. If required by my provider, I agree to participate in counseling with a counselor monthly. Failure to comply with counseling appointments will result in my provider's appointment being cancelled or not receiving my medications until I have seen the counselor.
12. I agree to abstain from all illegal substances. I understand if I fail three urine screens for illegal substances, that is grounds for dismissal from the office.
13. Due to the concerns with respiratory depression/inability to breathe from certain substances, discussion of any alcohol use and medical marijuana must be fully discussed with my provider to asses for safety
14. I agree that my provider has the right to call me in for a random pill count, urine screen, and/or administer a breathalyzer test. I understand that I will be subject to a urine drug screen on a regular basis, and I agree to their associated fees. If necessary, I understand that I may be subjected to a monitored urine drug screen. If I do not provider a urine sample, it will count as a failed drug screen. A failed drug screen includes testing positively for non-prescribed medications or the absence of prescribed medications in your system.
15. I understand that violations of this contract may be grounds for termination of treatment.

Special Considerations for Patient to Sign Off

I understand no prescription refills will be provided outside of monthly in person office visits
Signature _____

I must be seen in office every 30 days to continue controlled substance prescriptions unless otherwise noted by my provider. Should I miss an appointment, I will not get a refill until the following appointment which made lead to lapse of prescriptions
Signature _____

I will get monthly urine drug screens PRIOR to all in office appointments unless otherwise noted by provider. Prescriptions will not be refilled during appointments if the UDS results are not available for the provider to review and I will wait until my next appointment
Signature _____

Given the risks of long-term use of controlled substances, I agree to work with my provider to start to safely taper off of controlled substances if appropriate
Signature _____

Patient/Parent/Guardian Signature_____Date_____

Physician Signature_____Date _____

Witness Signature _____Date _____

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