Shlakman Psychiatric Services, PLLC

Samantha A. Shlakman, MD MPH
501 Church Street, NE suite 217
Vienna, VA 22180

phone: (202) 421-7408
fax: (703) 636-2644
shlakmanpsychiatricservices@yahoo.com

Practice Policies

Welcome to my psychiatric practice. The following pages contain information about my practice policies. Please read the following information carefully, and feel free to ask any questions you may have. I look forward to working with you.

Evaluation

1. All new patients to the practice will receive a psychiatric evaluation. This initial evaluation will last no less than two sessions, but may require multiple sessions depending upon the reason for presentation to the practice.

2. The initial evaluation may include a request for a medical examination, laboratory/medical studies, a psychological evaluation/testing, collateral information, and previous medical/psychiatric/psychological records. Included in this, I will request that you give your consent to me to communicate with your other health care providers, including any current or former mental health providers.

3. During the course of the evaluation, I will not prescribe any medication(s).

4. At the end of the evaluation, I will provide you with treatment recommendations.

5. If you were referred to me by another physician or provider, I will request your consent to contact that provider. I will contact him/her after our first session as well as at the end of our initial evaluation session(s).

6. The evaluation process does not commit either of us to continuing treatment. If you and I agree to enter into a doctor-patient relationship, it will commence after the conclusion of the initial evaluation.

Confidentiality

1. All patient information is confidential and cannot be released to a third party except with specific authorization by the patient. However, there do exist a few limits to this confidentiality:

   a. If child or elder abuse is revealed in the context of the therapeutic relationship, this must be reported to the proper authorities, and confidentiality may be broken.

   b. If the patient poses a serious danger to himself/herself or others, confidentiality may be broken in an attempt to provide medical/mental health treatment and/or safety.

   c. The physician is obligated to warn a person if he/she thinks this person is likely to become a victim of violence at the hands of a patient.

2. During the initial visit, I will ask all patients to sign a consent form indicating that they have given permission for me to lawfully use and disclose their protected health information for treatment, payment, and health care operations.

Treatment

1. Should you choose to make a commitment to either psychotherapy or pharmacological treatment, we will discuss your treatment plan. Please feel free to ask questions or voice any concerns at any time during the duration of treatment. We should both have a clear understanding of your treatment goals, and both commit to active participation toward these goals.

2. If I am prescribing medications for you, and you are receiving therapy from another provider the following are my policies in order to achieve the best therapeutic outcome:

   a. You must provide consent for full communication between myself, your therapist, and any other mental or psychological treatment providers you have, in order to discuss any medical or psychiatric treatment concerns.

   b. Abrupt termination with your therapist may result in the termination of our relationship. It is always best to discuss these issues before

any abrupt actions are made. If this occurs, and termination of our relationship is a result, appropriate referrals for follow-up care will be provided. Further, I will continue to provide treatment for up to 30 days, including up to a 30-day supply of prescription medication. This is in order to enable you to find another provider without interruption of care.

   c. Should a non-medication related emergency arise, you should contact your therapist directly. You may contact me as well, in addition to your therapist.

3. You must have appropriate medical care on an ongoing basis (internist or family/general practitioner). This should include yearly laboratory evaluations. If you have not had a physical exam or laboratory evaluation in the past year, I may ask you to do so.

4. If you are not already receiving it, I may at some point recommend therapy depending on the course of treatment. If in my opinion this become imperative, and you are not able to agree to this, it may result in the termination the therapeutic relationship. If this occurs, appropriate referrals for follow-up care will be provided. Further, I will continue to provide treatment for up to 30 days, including up to a 30- day supply of prescription medication. This is in order to enable you to find another provider without interruption of care.

5. Either of us at any time can reevaluate our therapeutic relationship. Please feel free to raise any concerns or questions at any time. If it becomes clear the therapeutic relationship has become ineffective or non-therapeutic, I may suggest that you seek alternative care, and I will provide you with appropriate referrals. Further, I will continue to provide treatment for up to 30 days, including up to 30-day supply of prescription medication. This is in order to enable you to find another provider without interruption of care.

Fee Schedule

1. All sessions/appointments are 45 minutes in length, unless other arrangements have been discussed and agreed to jointly.

2. All sessions are $300.00 unless otherwise agreed to jointly (and this document is amended and initialed by both parties to reflect that change) _______________________________________

3. Any sessions that are shorter than 45 minutes in length, will be billed at a prorated rate.

4. I do not bill for routine telephone calls including making/canceling appointments and calling in prescriptions to pharmacies. For more involved calls/concerns, I charge a prorated rate based on my general rate.

Billing

1. Payment is due in full at the time services are rendered.

2. At this time I am able to accept payments in the form of personal checks, cash, Mastercard, Visa, and Discover.

3. If a personal check is returned for insufficient funds, there will be a $25 charge, and full payment will be expected. If a second check is returned for insufficient funds, I will no longer be able to accept personal checks from the patient, and full payment will be expected.

4. At this time I do not participate in any healthcare insurance programs including Medicare. However, I will provide you with all the information necessary so that you may file a claim with your insurance company. I ask that you pay your bill in full after your session, and then independently collect reimbursement from your insurance company. Please be aware that insurance companies require that a diagnosis be submitted with each bill in order to receive reimbursement. If you have concerns about this, please feel free to discuss them with me. If you have any other questions about insurance reimbursement, please contact your specific provider directly.

Appointments, Cancellation, and Late Arrival Policy

1. Please provide two business days notice if you need to cancel or change an appointment, if you provide this, you will not be charged.

2. If you provide less than two business days notice to cancel or change an appointment, you will be charged the full appointment rate.

3. In the event that two scheduled appointments are canceled in a row, we will discuss the therapeutic relationship to determine its effectiveness as well as your satisfaction with it.

4. If I cancel an appointment, you will not be charged for that cancelled appointment.

5. In the event of a true emergency, this policy may be amended.

6. Each patient's session is reserved specifically for them. For this reason, visits will begin and end on time, and I am unable to extend a session beyond the agreed upon time. Thus, if a patient arrives late for his/her scheduled appointment, that time is lost from the session. If I am late, I will reduce the patient's fee proportionally, or make up the time when mutually convenient.

Coverage

1. I share vacation coverage with other psychiatrists. Another psychiatrist will be available for emergencies when I am on vacation/not available.

2. Your medical/psychiatric information will be shared with other physicians who provide coverage when I am on vacation/not available, in order to provide you with the best care.

3. Coverage emergencies primarily address medication emergencies or emergencies that might require hospitalization.

4. Prior to my leaving for a vacation, I will provide you with enough medication until our next appointment.

5. If I am not available, my voice mail will direct you to the covering physician.

6. I will inform you as far in advance as possible of scheduled vacation time.

Contact Information

1. My office number is 202-421-7408. Please use this number as my regular office hours number as well as my after hours number.

2. If I am unavailable, please leave a message and I will get back to you within 48 hours or the next business day. When you leave a message please leave your full name, the time and day you called, a call-back number, and whether I am permitted to leave a detailed message at that number. If you have not heard back from me within the above prescribed time frame, please call back as the message quality may have been unclear.

3. In the event of an emergency, please call 911. When you arrive at the hospital please call me, or have a health care provider at the hospital contact me.

My office is HIPPA compliant. Please note that although I share this office with other clinicians, we each maintain separate practices. I am not responsible for the other clinicians' patients or practice standards.

____________________________________ ____________________

Patient Name / Patient Signature Date

____________________________________ ____________________

Clinician Signature Date