Bell Psychiatric, PC

Thank you for inquiring about a psychiatric new patient appointment:

As the Medical Director for Bell Psychiatric, I thank you for inquiring about an appointment with me. I have been providing psychiatric care for over 30 years. I have had the privilege of providing care for families in Cool Springs for almost 20 years. As a psychiatric physician I seek to evaluate my patients through a holistic perspective which includes biological, psychological, social and spiritual components. My evaluation process leads to recommendations that may include medication management, education and psychotherapy. Often my treatment is designed to integrate with a patient's current counseling treatment.

Finding the "RIGHT" psychiatrist can at times be a complicated process, so to uncomplicate the process, I have included our PATIENT INFORMATION FORM and OFFICE POLICY FORM for your review. My Website, (**BellPsychiatric.com**) includes additional information about me and my psychiatric care for children, adolescents and adults.

If, after your review, you wish to move forward and schedule your first appointment, I ask you completely fill out the Patient Information Form and sign off on the last page giving Consent for both Office Policies and for me to provide you or your dependent with psychiatric care.

Once completed you may email or fax the form to my office at:

Support@BellPsychiatric.com or Fax to (615) 567-3381

Once we receive your completed form we will call you to schedule your appointment. Please note that we will require you to pay for your New Patient Appointment in full to hold the appointment. Thank you for understanding. I look forward to serving your psychiatric needs.

Kindest Regards,

William Bryan Bell, MD

Bell Psychiatric, PC

William Bryan Bell, M.D.
2001 Mallory Lane, Suite 303 Franklin, TN 37067
Office: 615-567-7881 Fax: 615-567-3381
Email us at Support@BellPsychiatric.com

PATIENT INFORMATION FORM

PATIENT DATA Date: _____

Patient Name: _____ Patient Birth Date: _____ Gender: ____

Patient E-mail Address:_____@_____

Patient Address: _____
Home City State Zip Code

Home Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Emergency Contact: Name: _____ Phone: (_____) _____-_____

Credit Card information: CC number: _____ _____ _____ _____ Exp ____/____ CCV: ____

Name on Credit Card: _____

Address for CC: _____
Home City State Zip Code

PRIMARY INSURANCE DATA for OUTPATIENT MENTAL HEALTH:

Dr. Bell is IN-NETWORK with BCBS (mental health/behavioral health benefits) only. We only file BCBS claims. We can provide OUT-OF-NETWORK policy holder's an appointment receipt which can be used to file for OUT-OF-NETWORK benefits.

It is the responsibility of the guarantor to know their own mental health coverage and benefits information at the time of each appointment.

Primary Insured Name: *(GUARANTOR NAME)* _____

Insured Birth Date: _____ Age: _____ Gender: ____

Insured Address: _____
(If different from patient) Home City State Zip Code

Insured Phone(_____) _____-_____ Insured Email Address: _____@_____

Primary Insured Employer: _____

Insured Identification Number: _____ Group Number: _____

Primary Insurance Company:_____ Effective Date:_____

Please note: MENTAL HEALTH (MH) coverage and benefits may be provided by an Insurance Company which is different than the Insurance Company providing general medical coverage and benefits.

MH PLAN NAME:_____Mental Health Benefits Phone: (_____) _____-_____

Mental Health Deductible: _____ Amt. Met: _____ Co-Pay: _____

Bell Psychiatric Office Policies

Office Hours:
Monday, Wednesday and Thursday 8:00 AM to 5:00 PM
Tuesday 8:30 AM to 5:00 PM
Friday 8:00 AM to 12 PM

Office hours are subject to change (holidays, vacation etc.). Any changes to normal office hours will be noted on the voice messaging and email system.

Cancellation Policy
The time for your sessions is reserved specifically for you. If you cannot attend your appointment, **PLEASE NOTIFY THE OFFICE AT LEAST 48 HOURS IN ADVANCE** to avoid being charged for an appointment. The fee for a missed appointment or late cancellation is the full private pay price for the appointment (even if you have BCBS insurance). Insurance will not cover the cost for a missed appointment.

Phone / Email Contact
Dr. Bell's administrative staff is usually available to answer calls during office hours. If staff is assisting other patients or you are calling after office hours, your call will be directed to voicemail. Please leave a detailed message. Dr. Bell's staff check and respond to your voice mail messages throughout the day. Most of the time staff will be able to respond to you the same day, however, we ask that you please allow us a minimum of 48 hours (not including weekend or holidays) to respond to your request. If you have an emergency situation during office hours please follow the prompts for leaving an emergency message.

You may also contact us through our office email service at support@BellPsychiatric.com. Please note that email messaging may not be secure and that you accept the inherent Privacy risks involved. Emails should only be used for non-urgent administrative purposes such as billing, scheduling, refill requests and any other general administrative question

EMAIL IS NOT TO BE USED FOR EMERGENCIES OR URGENT MATTERS.

Emergencies
During office hours you should call the office at (615) 567-7881 and follow the prompts for a psychiatric emergency. Please leave a detailed voice message about your emergency and include your name and phone number. Dr. Bell will triage your emergent situation then he or his staff will respond as quickly as possible. **If you cannot await a response, please call 911 or go to your nearest emergency room.**

After office hours you should call the office at (615) 567-7881 and follow the prompts for a psychiatric emergency. Please leave a detailed voice message about your emergency and include your name and phone number. Under most circumstances, Dr. Bell should be able to respond to your emergency within 30 minutes. **If you cannot await a response, please call 911 or go to your nearest emergency room.**

Psychiatric Emergencies are defined as:

- Suicidal thoughts or thoughts of harming others,
- An unexpected medication reaction with serious symptoms, or
- Any unusual behavior that your fear may lead to physical harm of yourself or others.

The Fee for an emergency phone consultation depends upon of the time spent in consultation with Dr. Bell. Insurance does not cover the cost for the emergency phone consultation.

PRESCRIPTION REFILLS ARE NOT CONSIDERED EMERGENCIES (please see prescription refill policy).

Prescription Refill Policy

NO REFILLS WILL BE GIVEN IF YOU HAVE AN OUTSTANDING BALANCE ON YOUR ACCOUNT. In general, all refill requests should be made **during** your appointment times. At the time of your appointment, you should be supplied with enough refills to last until your next appointment. Refill requests outside of visits are **only** for unusual/extenuating circumstances.

Prescription refills will incur a **$30** refill fee **FOR ALL REFILLS** requested outside of an appointment time.

If your prescription is a controlled substance (as is the case for most medications for ADHD), please see the "Controlled Medications" section as there are special policies for these prescriptions.

Prescription Refills for Non-Controlled Medications

If a refill is needed for a non-controlled medication outside of an appointment, call our office, make sure you have a scheduled follow-up appointment and let us know the medication name, dose and how you are taking it. Please include your pharmacy name and phone number as well. Allow at least 48 hours (business days) for this request to be completed. Contact your pharmacy to see know if and when your prescription will be available for pick up. Remember, you must first have a scheduled appointment with Dr. Bell or no refills will be given.

Prescription Refills for Controlled Medications

As with non-controlled medications, in general, all refill requests should be made **during** appointment times. Exceptions are made for changes to your medication between appointments or the unforeseen need for refills/rescheduling issues beyond your control.

Stimulants (most medications for ADHD, including Ritalin, Adzenys, Adderall, Focalin, Concerta, Vyvanse, etc.), many sleep medications (Ambien, Lunesta, etc.) and benzodiazepines (alprazolam, lorazepam, diazepam, clonazepam, etc.), are controlled substances. Since these medications are easily abused and there is an illegal market for these medications, the DEA and the State of Tennessee monitor prescribing and refill practices for these medications. If you are prescribed one of these medications, it is critical that you follow the controlled medication policy. The policy is as follows:

- You MUST take these medications as directed.
- If you feel you need to adjust your dose to a higher dose of the medication, you must call the office and consult with Dr. Bell prior to making any adjustments to your dose.
- You must be responsible with your medication and take measures to ensure that your medication is not lost or stolen.

If you require an early refill of your medication because you have adjusted your dose without consulting Dr. Bell or because your medication was lost/stolen you are in violation of the controlled medication policy. Dr. Bell understands that unexpected circumstances, out of your control, may result in your needing an early refill for your medication and will allow ONE violation of the controlled medication policy to allow for these circumstances. If your controlled medication was lost/stolen medications, you will be required to file a police report and present this report to Dr. Bell prior to any refill. You will be charged $100 fee for an early refill of your controlled medication. Any subsequent violations of the policy will result in your termination as a patient with Dr. Bell. While this policy may seem harsh, due to the nature of these medications, Dr. Bell must be able to manage these prescriptions responsibly and in a manner to minimize any potential abuse.

To make a refill request for controlled medications, leave Dr. Bell a message on his voicemail (615-567-7881) with your exact medication request.

Email and Cell Phone/Texting Policy

For reasons of privacy/confidentiality, Dr. Bell does not conduct treatment through email or texting. Conducting treatment via email violates Dr. Bell's commitment to privacy and confidentiality, lacks the back and forth of natural conversation, and is fraught with the opportunity for misunderstanding. Dr. Bell's policy is to meet to discuss things or at least have a telephone conversation. Dr. Bell will use email only if he has specifically

requested you send him specific information by email and he is expecting it. All email messages sent to Dr. Bell at his request should be accompanied with voicemail messages asking him to look for the email message.

Fees and Payment
Please contact the office for a schedule of current fees. Your fee for your appointment as well as any account balance is due in full **at the time of service**. This includes expected copayment, coinsurance, deductibles, and other charges which are not covered by insurance. For our private pay and out of network patient's this includes the full price for the appointment and any other miscellaneous charges incurred in between appointments. Payment may be made by cash, check or major credit card. We do not accept partial payments nor payment plans. If you are unable to pay in full at the time of your appointment, your appointment will be rescheduled and no prescription refills will be given until full payment is received.

Disclaimer about mental health coverage and benefits: We do our best to obtain the most current mental health coverage and benefits information from the Blue Cross Blue Shield website. The explanation of benefits and insurance payment after your claim is processed will determine the final cost of the appointment.

Outstanding Balance Policy: While most office charges are paid in full at your appointment, at times you may incur charges for emergency calls, prescription refills outside of appointment, no-show charges, reports, and / or letters, etc. In the event you incur a charge outside of your appointment, we request your authorization to run your credit card at the time the charge is incurred. We will notify you of the charge and credit card payment. It is our office policy to keep your credit card information securely on file at our office.

There will be a monthly billing charge of $25 for patients who have forgotten to pay their bills. If three months pass without payment of the bill, Dr. Bell will be required to terminate you from his care and send your bill to the collections agency. Accounts sent to collections will incur a 33-1/3% collection fee.

DR. BELL WILL NOT PROVIDE APPOINTMENTS NOR PROVIDE PRESCRIPTION REFILLS for patients with outstanding balances.

Release of Private Healthcare Information (PHI)
Because of the laws governing the release of Private Healthcare Information, we will be unable to release information pertaining to your healthcare without a completed and signed Release of Information form. Once this is obtained we can forward patient records or a summary of treatment to licensed professionals at no charge as a professional courtesy. Request to release this information to non-healthcare providers including attorneys, underwriting companies, etc., will be billed at cost for supplies, mailing and administrative processing time. It is our policy to not release records directly to a patient without first reviewing the record together. Any request for release of records must allow at least 3 weeks preparation time.

ASSIGNMENT AND RELEASE

OFFICE POLICY AGREEMENT

I, the undersigned, certify that I have read the OFFICE POLICIES above and am willing to abide by them.

For IN NETWORK Mental health coverage and Benefits with BCBS.

I acknowledge that I (or my dependent) have insurance coverage (as noted above). If Dr. Bell is a contracted provider with my insurance, I am assigning directly to William Bryan Bell, MD all insurance benefits, if any, otherwise payable to me for services rendered. If my insurance company fails to reimburse Dr. Bell, I recognize that I am still financially responsible for all charges. I, hereby, authorize Dr. Bell to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

For OUT OF NETWORK and PRIVATE PAY.

Since Dr. Bell is not a contracted provider with my insurance, I understand that I am financially responsible for all charges for services rendered. I understand that I must submit my own insurance claims and have my insurance reimburse me directly for services rendered.

Further, I consent to leaving my credit card information on file to be kept securely for payment only on my account. I will allow Dr. Bell or his staff to run my credit card for charges incurred for services (which cannot be billed to my insurance) rendered in between appointments and / or any balance left after a BCBS claim is filed.

I acknowledge that if my account is sent to collections for my failure to pay, I will be need to pay any balance, a 33 1/3% of balance surcharged fee and any legal fees associated with the collections process.

Finally, please note that your attendance at each appointment helps facilitate the healing process. With this in mind the automated system will attempt to email and/or call/text to remind you of your appointment. Ultimately, it is your responsibility to keep your appointments even if the reminder message fails. It is our expectation that you will attend your appointment if at all possible, therefore, failure to cancel your appointment without at least 48 hours notice in advance of your scheduled appointment date will result in a charge for the full private pay price of the appointment. (Voice message will be accepted 48 hours prior to date). Thank you for your understanding.

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date

OFFICE TREATMENT AGREEMENT

I agree and consent to participate in the psychiatric / behavioral health care services offered and provided by William Bryan Bell, MD. If the Patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____	_____	_____
Responsible Party Signature	Relationship to Patient	Date