**Stephen E. Brown, MD, PLLC**

**Office Policies**

**OFFICE HOURS**:

Sessions are by appointment only: Appointments are typically available during my regular business hours, which may be found at www.StephenBrown-MD.com.

**APPOINTMENTS:**

Initial Psychiatric Evaluation appointments are 75-90 minutes, psychotherapy sessions are 50 minutes, and medication follow-up appointments are 15 minutes. Fees are based on time and sessions that go over will be charged accordingly. With the exception of emergency situations over which Dr. Brown has no control, appointments begin promptly as scheduled. Your appointment time is reserved for you and you are encouraged to be certain that you arrive on time. If you are late, you will cut into your appointment time but will be responsible for the fee for the full time.

**APPOINTMENT CHANGES/CANCELLATIONS:**

Patients are requested to notify the office of appointment changes or cancellations as far in advance of the scheduled time as possible to allow another patient to utilize the time. With the exception of emergency situations patients must give Dr. Brown a **minimum** notice of 24 business hours. Monday appointments must be cancelled by the corresponding time on Friday. If this minimum notice is not respected, the patient may be charged a fee. In the case of inclement weather, call the office first thing in the morning to see if the office has been closed. If not, and you are uncomfortable driving, you may have a phone session instead. In that case, you must call the office **prior to your appointment by at least one hour** andDr. Brown will call you at your scheduled appointment time. If, for any reason, Dr. Brown must cancel an appointment, you will be advised at the earliest possible time.

**FEES AND PAYMENT:**

Most health insurance policies have a provision for mental health benefits. While Dr. Brown provides statements for patients who wish to file for reimbursement on their own, he does not file claims directly with health insurance companies. You will need to check with your insurance carrier for details about your specific coverage. Dr. Brown does not provide service to insurance companies; he provides service to you, his patient. For that reason, you are expected to pay at the time of the appointment. Fees are payable by cash, check, Visa, MasterCard, American Express, Discover, and debit cards.

**CONTACT POLICY:**

To provide quality care to his patients, Dr. Brown strives to promptly return calls to patients. There may be a charge for phone calls based on the time spent per call. For more extensive phone calls, please schedule a phone appointment with Dr. Brown. Although patients have the option to communicate via e-mail, patients are advised that e-mail transmissions are not secure and therefore may not be confidential.

**EMERGENCY CALLS**:

During office hours, for calls that are urgent but not life threatening, please leave a voicemail message if Dr. Brown is not available to answer your call. For those that represent a life threatening emergency, whether during office hours or not, always call 911 immediately or go to your local emergency room.

**REPORTS, LETTERS, DISABILITY FORMS:**

May be provided at Dr. Brown’s discretion and may incur a fee.

**PRESCRIPTION POLICY:**

If you have been given certain controlled prescriptions they may be regulated by the Commonwealth of Virginia. Please be aware that these prescriptions **must be filled within 7 days**, and no refills are allowed. Dr. Brown may access information contained in the Virginia Prescription Monitoring Program files on any DEA Schedule II, III or IV prescriptions dispensed to a patient.

Take all medication as prescribed. Every medication has been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing any medications is both medically contraindicated and illegal. Your cooperation is appreciated.

Prescriptions will **only** be called in for those who are current patients and who maintain their regularly scheduled appointments. All prescription refill requests should be called in a minimum of three business days before your medication runs out. **Prescriptions for controlled substances will not be renewed before they are scheduled to run out**. When requesting a refill, please provide all information regarding theprescription you are requesting, including your pharmacy name and number.

There will be a $25 fee for processing prior authorization requests required by your insurance carrier for prescribed medications.

**TERMINATION POLICY:**

Patients are under no obligation to continue services, and may terminate treatment at any time. However, Dr. Brown strongly urges that you notify him in person during a session regarding this decision, so that it can be discussed openly. Dr. Brown’s goal is to make all terminations as therapeutically helpful as possible.

**Consent to Treatment**

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| I |  | | am presenting myself (or my child or ward, if I am a | | | |
|  | | parent or guardian) for diagnosis and treatment by Dr. Brown. I voluntarily consent to the rendering of any | | | | |
|  | | such care, including psychiatric examinations, diagnostic procedures, and medical treatments, as may in his | | | | |
|  | | professional judgment be deemed beneficial or necessary. I acknowledge that no guarantees have been made | | | | |
|  | | to me as to the effect of any such examinations or treatment. | | | | |
|  | | | | | | |
| I understand that the purpose of any procedures or medical treatments will be explained to me and are subject to my consent. | | | | | | |
|  | | | | | | |
| I understand that while any course of therapy is designed to be helpful, it may at times be emotionally or physically difficult or | | | | | | |
|  | | uncomfortable. | | | | |
|  | | | | | | |
| I understand that I am fully responsible for all charges incurred, regardless of any insurance policy(ies). I agree to pay in full any | | | | | | |
|  | | and all debts that I may incur in the course of treatment for either myself or as a guarantor. I further understand that all | | | | |
|  | | fees are payable at the time of service. | | | | |
|  | | | | | | |
| My signature below is my acknowledgement that (1) I hereby give my authorization and consent to treatment; | | | | | | |
|  | | (2) I am bound by this agreement; and (3) repeated violations of this agreement may be grounds for termination of my treatment. | | | | |
|  | | | | | | |
|  |  | | |  | July 3, 2012 |  |
|  | Patient/Guardian signature | | |  | Date |  |