Mona Maaty M.D.
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KINTSUGI behavioral health

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OFFICE POLICIES AND PROCEDURES

Please note that this **must** be completed ***prior*** to scheduling an initial appointment.

General: Dr. Maaty is unable to accept patients with **Medicaid** and/or **Medicare** (even if no claim is submitted).

a. I affirm that I do not have **Medicaid** or **Medicare** insurances. I understand that if I do enroll in Medicare or Medicaid, I will notify Dr. Maaty in writing immediately or else I will be responsible for any resulting penalties/fees.

Initial _____

b. Dr. Maaty does **not** split treatment with other prescribers of psychiatric medication. If it is discovered that a patient is receiving psychiatric medication from another mental health provider, the patient will be terminated from the practice effective immediately.

Initial _____

Financial Agreement: The initial appointment fee is **$350** (~60-90 min)**.** Follow-up medication management only appointments are **$200.** Psychotherapy sessions (which may include medication management) are **$300** and are typically 50 minutes in length. There is an additional **$60** per **10-minute** increment **over 50 minutes.**

Dr. Maaty is **not** in network with insurance companies. In general, many PPO insurances reimburse a percentage of eligible out-of-network expenses once a deductible is met. Upon request, Dr. Maaty can provide a "Superbill" which is a document listing the procedure code(s) and associated fee(s).

a. I knowingly, voluntarily, and specifically understand that I am selecting Dr. Maaty as an out-of-network provider for health care services.
b. I understand that I may request Dr. Maaty's assistance in determining whether my insurance has out-of-network benefits. I also may request assistance in determining the estimated amount for services as well.

c. I understand that I should call my insurance company to determine the best option for me and for further information.

d. I understand that I may ask Dr. Maaty for assistance in submitting a "Superbill" for reimbursement.

e. I understand that I am responsible for the fee in full and that payment is expected at the time of service.

f. I understand and consent to providing a credit card number before the initial intake. Dr. Maaty maintains the protection of your information via PCI-compliant standards required by Integrity Payment Systems. The charge on your statement will appear as "MONA MAATY MD 973-832-1808 NJ."

g. I understand and consent to being charged to this credit card automatically for any no-show/late cancellation appointments (see *No-show/Late Cancellation* policy below for specific penalty fees).

h. I understand that I am responsible for any fees incurred if I require more time than was initially scheduled. I understand that Dr. Maaty will alert me once I have exceeded the initially allotted time. The additional fee will remain at the usual rate of **$60** per additional 10-minute increment over 50 minutes.

Initial _____

After-hours calls: After-hours calls are routed to voicemail and will be checked the next business day. Therefore, if you are or believe you are experiencing a medical or psychiatric **emergency,** including suicidal or homicidal thinking, side effects to medication, or any other urgent or time-sensitive matter in which you need an immediate response, please **call 911** or go to your closest **emergency room**. **Initial _____**

Appointments:

a. I understand that Dr. Maaty is unable to accommodate requests for same day appointments or walk-ins.

b. I understand that no new medication requests will be granted over the phone as these require an appointment.

Initial _____

Initial Appointment:

a. I understand that in some cases a prescription may not be written during the initial evaluation. Usually, in these cases, additional information from a previous provider may be necessary to choose the appropriate treatment. Sometimes, in order to provide the appropriate level of care, a patient may need to be seen in a different treatment setting that includes support staff and/or case management. In these instances, a referral will be provided.

Initial _____

No-Show/Late Cancellations:

a. I understand that if I do not show within **15 minutes** from the start of my appointment time, unless there are extenuating circumstances deemed significant, I will be marked as a "no-show" and will be automatically charged the fee that was due for that session.
b. I also understand that I must provide **24-hour notice of cancellation.** Clients who **"no show"** will be charged the **full** fee owed for that appointment. Clients who provide **<24 hour** notice will be charged **50%** of the fee owed for that appointment.
c. I understand that **three** no shows/late cancellations may result in termination from the practice.

Initial _____

Communication: As a service to patients, we have a secure/HIPAA-compliant online portal.

a. I understand that If I decide to communicate sensitive information through my personal email or by phone (as in call/text), I am consenting to its associated potential security and confidentiality risks.

b. I understand that I have the right to revoke authorization for any method of communication at any time.

c. I understand that I will automatically receive e-mail and text reminders unless I request to opt-out of such reminders.

Initial _____

Additional Services: If you request additional documents which are not a part of your medical record as in letters to organizations, landlords, insurance reviews etc., such services will be billed at an hourly rate of $360. Please note that disability paperwork, FMLA, and other letters on your behalf will not be produced until at least 6 months and 10 visits from our initial session. Further, if a patient has met that minimum, such paperwork may be declined and is up to the discretion of Dr. Maaty.

Initial _____

Etiquette: Disrespectful, abusive behavior or harassment towards any staff will not be tolerated and such behavior will result in termination from the practice.

Initial _____

Primary Care: Psychiatric medications are chosen based upon many factors including lab results and comorbid medical issues.

a. I understand that it is strongly recommended that I have a recent set of lab results and be under the care of a primary care provider. Certain medications may be restricted if there is concern about comorbid medical issues.

Initial _____

Consent for Medication History Check: There are certain measures that can help Dr. Maaty ensure your safety.

a. I understand and give consent to Dr. Maaty to perform a computer-based medication history check prior to my initial appointment and during the course of treatment. I understand that this will pull forward **all** prescriptions filled at any pharmacy within the past 18 months regardless of method of payment.
b. I understand that controlled substances are governed by federal and state laws and providers are required to check the New Jersey Prescription Monitoring Program which will list all controlled substances regardless of method of payment.

Initial _____

Refill Request: You may request a refill by sending a SPRUCE message or a message through the secure patient portal. Please ensure that you have provided enough notice before running out of medication.

a. I understand that should I no-show or cancel late, I may be required to be seen first for an appointment in order to refill a medication (***Controlled substances*** require visits every 2 months).
b. I understand that I will be charged **$50** for refill requests resulting from a missed appointment (as long as the refill request is deemed appropriate). *Note*: *This is allowed once per calendar year and does not include any late cancellation/no show fees. This amount will be charged to the credit card used in the last encounter.*
c. I understand that a request for a refill for a controlled substance will be **$60**. (***Controlled substances*** require a session every 2 months). *This amount will be charged to the credit card used in the last encounter.*

Initial _____

Controlled Substances:

a. I understand that Dr. Maaty generally does not prescribe Xanax.
b. I understand that Dr. Maaty does not prescribe any benzodiazepine or certain sleeping medications (i.e. Ambien/zolpidem) in conjunction with narcotic pain medications (i.e. morphine, oxycodone) due to the potential risk of an accidental overdose.
c. I understand that I will notify Dr. Maaty if narcotic pain medications are prescribed to me.
d. I understand that I must have a session at least every 2 months for controlled substances.
e. I understand that there will be no early refills of a controlled substance if it is finished before the due date. If withdrawal from the controlled substance will result in physiological withdrawal symptoms, I will be directed to go to the ER for a medical detox.
f. If I take a controlled medication in a way which is considered unsafe and against Dr. Maaty's advice (as in mixing certain anti-anxiety/sleeping medications with alcohol or taking such medications with

pain medications), Dr. Maaty can stop the medication immediately and refer me to the ER for a medical detox.

g. I understand that if a prescription for a controlled substance is lost or stolen, prescriptions will not be refilled or replaced unless a police report is provided.

h. I understand that for controlled substances, Dr. Maaty may request a random urine drug screen which should be completed within 48 hours.

i. I understand that if I am prescribed a controlled substance of a similar class by different prescribers, without the notification and consent of the prescribers, I will be terminated from the practice.

j. I understand that if medication is sold, exchanged, shared or if any prescription is altered, I will be terminated from the practice.

k. I understand that if I do not show for an appointment in which I am due for a prescription for a controlled substance, I may not receive a prescription and may be instructed to report to the closest ER until I can be seen for an appointment. **Initial _____**

I have read these policies, understand the contents, and agree to the terms. I have had my questions regarding this policy satisfactorily answered. This authorization will remain indefinitely. I understand that Dr. Maaty has the right to change this notice and make such changes effective for all past, present, and future treatment. I understand that the most up-to-date practice policies can be found at the website: kbhealth.org.

Printed name _____

Signature  **Date _____**