Norana Caivano, MD
406 Massachusetts Ave
Arlington, MA 02474
781-214-7275

OFFICE POLICY

The following is a summary of the structure of my working arrangements with my patients in my psychiatric practice. It is intended to assist in clarifying questions that commonly arise and to establish the conditions of treatment. You may refer to a copy of this consent at drcaivano.com.

Insurance: I currently do not accept insurance.

Fee For Service: The initial visit is 50 minutes and $300. The fee for 30 minute medication visits is $250. The fee for 50 minute combined psychotherapy and medication management sessions is $300. *Payment is due at time of visit*.

Payment: Please refer to the Financial Agreement and Credit Card Authorization Form for policies regarding payment, missed appointments, and late cancellations.

Emergency: I am usually able to answer all routine calls within twenty four hours during business hours. I do not check or respond to routine messages left on evenings or weekends until the next business day. If you have an emergency outside normal business hours, please call my office (781-214-7275) and listen to the instructions. If for any reason you are unable to wait for a response or I am unavailable, you should go to your nearest emergency room, or call 911. Do not use email or other message systems in emergencies or to deal with urgent matters.

Other Services: Administrative services—such as record review, report writing, preparation of forms or correspondence to other parties, such as insurance companies, employers, or schools—will be charged at an hourly rate of $300 per hour. Telephone contact in excess of 10 minutes will be billed at an hourly rate of $300 per hour, beginning at the time of initiation of the call. *None of these services are billable to, or reimbursable by, insurance companies.*

Medical Issues: In order to maintain a high quality of care, I ask that each patient have or establish a good working relationship with a primary care physician, with whom I may coordinate care, should the need arise for medical evaluation or consultation in the course of treatment with me. All female patients need to maintain regular gynecologic care.

Release of Information: Your signed authorization is required to permit the discussion of your case with the referral source and other health care providers and facilities for the purposes of diagnosis and treatment. Your diagnosis must be released to your insurance company in order to process any claim or laboratory test.

Confidentiality: All information from your treatment is held strictly confidential, with the following exceptions:

You agree in writing to permit such a release
Physical danger to yourself
When I am out of the office, some basic information must be provided to the doctors who cover my practice
Occasional consultation with colleagues in order to provide you with the best care (I make every effort to maintain confidentiality of any identifying information)
If you are involved in a lawsuit, a court may subpoena my records
Danger to others
Suspicion of child or elder abuse or neglect
In the latter 2 cases, I am required by law to inform potential victims and legal authorities so that protective measures can be taken.

Electronic Communication and Billing: Please refer to the HIPPA and email communication agreement found on my website at drcaivano.com. All patients will be invited to use electronic health records to communicate via secure email, update personal information, access statements, have medications securely refilled through escript. If you do not wish to use this service, please inform me.

Substance Abuse: Occasionally chemical dependency issues arise during the course of treatment that are over and above recreational use and that are adversely impacting medication treatment and/or psychotherapy. In such situations, I would advise you of the significance of the condition and provide referrals to chemical dependency treatment programs. If for any reason an individual prefers to maintain his or her habit and refuses to accept chemical dependency treatment within a reasonable period of time, then that individual is effectively terminating care with me and is responsible for transferring their care to another physician.

Legal action: If legal actions occur in which I am requested or subpoenaed to provide testimony (such as a custody case), you will be responsible to pay me directly for providing the following services: (a) the time spent preparing for the court, (b) the time spent for transportation to/from court **,** and (c) the time spent appearing in court. Charges for legal services will be billed per hour. This fee is NOT reimbursable by a Third Party Payer and is therefore the full legal responsibility of the client.

Consent: I have read this information sheet and understand and accept its terms.

Name: _____

Signature: _____

Date: _____

Financial Agreement

A **Credit Card Authorization** is required for treatment with Norana Caivano, MD.

In case of cancellations with less than 48 hours notice and no shows for scheduled sessions, you will be charged a $_____ appointment fee. An additional $25 is assessed for returned checks.

Please note that missed appointments and late cancellation fees are not covered by your health insurance and will not be reimbursed. You will be solely responsible for these fees.

Multiple missed appointments may result in you having to pay in advance, and/or eventual termination of services. Unless other arrangements are agreed upon, all fees that are 90 days past due will be sent to a collection agency.

This form will be securely stored in your clinical file and may be updated upon request at any time.

Forms of Payment: The following forms of payment are accepted through this practice: Cash and Personal Checks.

Monthly Statements: Several of my clients are using their out-of-network insurance benefits to pay for therapy. You will receive an insurance-ready statement on a monthly basis through ntreatment.com patient portal site.

Please feel free to discuss any billing matters with me as necessary.

Signature:_____Date:_____

Credit Card Authorization Form

I, _____, am authorizing Norana Caivano, MD to use my credit card information to charge my credit card for an agreed upon rate of $_____ if I cancel my appointment with less than 48 hours notification or if I fail to attend my scheduled appointment without notice.

Card Type (circle one): Visa MasterCard Discover

Card #:_____ Expiration Date:_____

Name as Printed on Card:_____

Verification/Security Code (3 digit code on back of card by signature line):_____

Billing Address:_____

City:_____ State: _____

Zip:_____

Signature:_____Date:_____