Cherry Creek Psychiatric

Welcome to Cherry Creek Psychiatric, the office of Dr. Benjamin Lipman, DO. Please take a moment to read through the following, as we may not have the chance to review all of this information together.

In this packet you will find sections regarding:

1. Contacting the Office
2. Financial Responsibilities, Billing and Payment Agreement
3. Office Policies
4. Patient Demographic Information
5. Release of Privileged Information
6. Therapy Partner Financial Agreement
7. Your Copy of Sections 1, 2 and 3

Section 1: Contacting the Office

Cherry Creek Psychiatric's main office number is **720-432-4660**. Messages are retrieved throughout the day, Monday through Friday. Please allow 24-48 hours for a return call during the week. In the case of **emergency only**, you may contact Dr. Lipman on his personal phone, at 518-221-5047. Please leave a message, as he is not always able to answer. If you, or the patient you are calling about, are in crisis and Dr. Lipman is not accessible, please go to your nearest emergency room, or call 911 for assistance.

At this time, e-mail communication is not accepted.

The office address is:

Cherry Creek Psychiatric
Dr. Benjamin Lipman
950 South Cherry Street, suite 1140
Denver, CO 80246

The office fax is:

720-379-4647

-please note this fax line is confidential and should not be given out to pharmacies

_____ _____

Signature: Date:

Section 2: Financial Responsibilities, Billing and Payment Agreement

Cherry Creek Psychiatric does not work directly with insurance providers. Financial responsibility for treatment lies with the patient, or the patient's financially responsible party.

Payment is processed through Therapy Partner, an online credit card processing service designed for psychiatrists and psychotherapists. At this time, Visa, MasterCard, and Discover are accepted. There are no additional processing fees for this service. Unless otherwise agreed upon, credit card will be the primary form of payment for professional services. A valid credit card must be on file at all times. Credit card numbers are not kept on file in this office.

Therapy Partner and Cherry Creek Psychiatric will provide an itemized bill and receipt that you may submit to your insurance provider for reimbursement as per your policy. There is no guarantee of coverage. You are responsible for all charges for professional services rendered on behalf of the identified patient, at the time of service. Billing statements will contain session billing codes and dates of service, along with the commonly required information insurance companies generally use to reimburse for out-of-network services. Please be aware that diagnosis codes are included on these statements. **For your privacy, please specifically request if you would not like diagnostic codes included on these statements**.

It is Cherry Creek Psychiatric's policy that you will be charged for missed appointments unless notice is given to cancel at least **two full business days** before the scheduled appointment. Please note that insurance companies do not reimburse for missed/cancelled appointments. Also, while Dr. Lipman may agree to speak over the phone for a scheduled appointment, insurance companies generally do not reimburse for telephone appointments.

Your signature below indicates that you understand Cherry Creek Psychiatric's financial policies and certifies that you are financially responsible for services provided. You are responsible for any collection or attorney fees or court costs associated with the use of outside individuals or organizations required for collection of your account. Late payment fees may also be assessed, according to Colorado State law, unless otherwise agreed upon.

_____ _____

Signature: Date:

Section 3: Office Policies-Please read and initial each of the following

□ All appointments must be cancelled greater than two business days in advance to avoid being charged the full session fee. Please be aware that insurance companies will not reimburse for sessions not attended.

□ No show/no call sessions will be charged for at the full session fee, regardless if an appointment is rescheduled within the same business week.

□ **Special considerations for ongoing therapy/regularly scheduled appointment times**: Committing to ongoing and intensive psychotherapy is an important decision, one that must be undertaken understanding not only the psychological commitment, but the time and financial commitments. Regularly scheduled appointments represent a large time commitment for both you and your treatment provider. In order to ensure that your day can be planned accordingly, session times are accurately kept. Appointments are never double-booked or overlapped. In order to provide this consistency, your financial responsibility for the agreed upon appointment time is necessary. **Please read the following section carefully:** Considerations to waive appointment fees for sessions not attended or cancelled within two business days will be made in the case of emergencies, safety, and serious unavoidable events that require immediate attention. These events might include taking a child or family member to the hospital, the death of a family member, or an emergency medical procedure. Please understand that session fees cannot be waived in the case of childcare issues, minor illness, or work-related incidents. It is understandable that some appointments may have to be missed, however, please be aware that the majority of late cancel/missed appointments are charged for.

□ Effective treatment often requires communication with outside providers, including primary care physicians, other physicians, schools, and outside therapists. Consultations with other providers or medical chart reviews are billed for by time, at a prorated amount of the agreed upon session rate. You will not be billed for consultation time without prior approval. Insurance companies may not reimburse for these communications.

□ At your request, letters and other paperwork relating to treatment may be provided. Documents commonly requested include letters to schools, letters to other treatment providers, treatment plans and recommendations, prior authorization medication requests, and communication with insurance companies. Letters, paperwork, and communication to insurance companies are billed for by time, and at the agreed upon prorated session rate.

□ Emergency encounters between sessions lasting greater than five minutes are subject to charges based on the time for the interaction, plus ancillary activities like documentation and communication with outside providers. Examples of an emergency encounter would include patient hospitalization, or emergency phone calls. Charges are based on the prorated session rate.

□ Prescription medications are generally given in an amount sufficient to last until the next appointment. If an appointment is missed and medications are needed, a bridge prescription may be written to cover the amount of medication needed to attend that next appointment. Please be aware that some insurance companies will not pay for two prescriptions for the same medication filled within the same 30-day period.

□ Refill requests must be made by the patient, or the patient's caretaker. Refill requests made by a pharmacy are not honored, as they are often inaccurate.

Cherry Creek Psychiatric Patient Information Form

Today's Date:	PCP:

PATIENT INFORMATION

Patient's Last Name: First:	Middle:	Marital status:

Birth date:	Age:	Sex:

Address: City: State: ZIP:

Social Security no.:	Home phone no.:	Cell phone no.:

Who referred you to this practice?

RESPONSIBLE PARTIES INFORMATION (ONLY FILL OUT IF PATIENT IS A MINOR)

Mother of Patient Name:	Address: City: State: ZIP:	Contact: Cell: Home:
Father of Patient Name:	Address: City: State: ZIP:	Contact: Cell: Home:

INSURANCE INFORMATION

Is this patient covered by insurance? ○ Yes ○ No

Please indicate primary insurance carrier:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:

Patient's relationship to subscriber:

IN CASE OF EMERGENCY

Name of spouse, local friend or relative:	Relationship to patient:	Home phone no.:	Cell phone no.:

The above information is true to the best of my knowledge. I understand that I am financially responsible for all charges and that insurance information is only being collected to expedite communications (i.e. Prior Authorization Requests), when applicable. By providing my insurance information I am authorizing Cherry Creek Psychiatric to speak with my insurance company and to release any information required to expedite these types of communications.

Patient/Guardian signature(s) Date

Section 5:

Release of Privileged Information

I hereby authorize Cherry Creek Psychiatric and Dr. Benjamin Lipman to obtain medical information about, and/or provide medical information regarding:

_____ _____

Patient Name Date of Birth

To and/or from:

_____

_____

_____

_____

_____

I hereby release Dr. Lipman from any liability in furnishing this information.

_____ _____

Signature Date

ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered. We accept: Visa, MC and Discover.

Client Information:

Client Name: _____ Date of Birth: _____

Address: _____ City_____ State: _____ Zip: _____

Home Number: _____ Mobile Number: _____ SSN: _____

Email: _____

Billing Information:

Please indicate the information associated with the credit card you wish to use.

Name: _____

Address: _____ City _____ State: _____ Zip: _____

Email: _____

I authorize all service fees to be deducted from the card ending in _____ (last four digits of the card)

Please enter the CVV code _____ (last three digits on back of card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties:

Full Name(s) _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card, and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

_____ _____

Cardholder Signature **Date**

Payments are processed by Therapy Partner. Therapy Partner is a registered ISO/MSP of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

Debit Card Information: Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover

Card Number: _____ Expiration Date: _____

YOUR COPY

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