MTI PSYCHIATRY

# NEW PATIENT PACKET

**Updated: October 11, 2023**

8271 Melrose Ave, STE 110, Los Angeles, CA 90046
627 N Larchmont Blvd, Los Angeles, CA 90004

949-436-9099

mingram@mtipsychiatry.com

MTI PSYCHIATRY

# PRACTICE POLICIES

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH |
|---|---|
| | |

| ADDRESS | PHONE NUMBER |
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## PRACTICE POLICIES

Welcome! Agreement to the following terms and conditions is required for the patient ["you" or "your"] to receive psychiatric services from Dr. Michael T. Ingram, Jr., M.S., M.D. ["provider" or "me" or "my" or "I" or "we" or "our"]. If you do not agree, I will be glad to give you referrals to other providers.

### CLINICAL SERVICES

You are providing consent to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

If you are in a life threatening medical and/or psychiatric emergency or are a threat to public safety, you agree to call 911 immediately or go to the nearest emergency room. For non-life-threatening inquiries please feel free to reach me anytime between 9am and 6pm by phone, email, or luminello messaging. Please know I will do everything I can to respond as soon as possible. You can expect a response within 48 hours.

Note that I do not have admitting privileges, nor am I affiliated with or on staff at any hospital. Should I deem more intensive services are needed than I can provide, I will do my best to ensure safety and obtain the appropriate level of care, but I cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records unless I believe that seeing them would be emotionally damaging. If this is the case, I will be happy to provide the records to an appropriate mental health professional of your choice or to prepare an appropriate summary instead. Because client/patient records are professional documents, they can be misinterpreted and can be upsetting. If you wish to see the records, it is best to review them with me so that we can discuss their contents.

**IF YOU ARE SEEING ME FOR MEDICATION MANAGEMENT:**

- You agree to contact your therapist first (if applicable) for any psychiatric emergency or crisis, unless it is related to medication. If the emergency or crisis is related to medication, you agree to contact me immediately. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.
- You agree to inform me if you are considering stopping therapy or have actually stopped.

- You agree to see me in person or via telemedicine video conferencing at LEAST once per month for the first three months. After the first three months, you agree to see me in person or via telemedicine video conferencing as frequently as clinically appropriate based on my clinical judgement.
- You understand that medication refills for scheduled I, II, III, IV, or V medications will not be provided unless you've attended a scheduled appointment within the previous two months for schedule I, II, or III medications or three months for schedule IV or V medications.
- You understand that no schedule I, II, III, IV, or V medication will be prescribed until you've been seen in-person at least once.

**IF YOU ARE BEING PRESCRIBED A SCHEDULE I, II, OR III MEDICATION:**

- You agree to see me in office or via telemedicine video conferencing AT LEAST once every two months.
- You understand that refills for schedule I, II, or III medications will not be provided unless you've attended a scheduled appointment within the previous two months.
- You agree to see me in office (i.e., in-person) AT LEAST once per year.

**IF YOU ARE BEING PRESCRIBED A SCHEDULE IV or V MEDICATION:**

- You agree to see me in person or via telemedicine video conferencing as frequently as clinically appropriate based on my clinical judgement.
- You understand that refills for schedule IV or V medications will not be provided unless you've attended a scheduled appointment within the previous three months.
- You agree to see me in office (i.e., in-person) AT LEAST once per year.

## TELEMEDICINE & ELECTRONIC PRESCRIBING

If using Telepsychiatry services, electronic prescribing is available. In compliance with federal and state law, all patients prescribed scheduled/controlled medications must be seen IN-PERSON AT LEAST ONCE prior to being prescribed a controlled medication.

## RYAN HAIGHT ONLINE PHARMACY CONSUMER PROTECTION ACT OF 2008

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was created to regulate online internet prescriptions, is enforced by the DEA (Drug Enforcement Agency) and also imposes rules around the prescription of controlled substances through telepsychiatry.

The Act requires any practitioner issuing a prescription for a controlled substance to conduct an in-person medical evaluation (with certain specified exemptions) prior to prescribing controlled substances. Per the Act, the prescribing practitioner is required to have conducted one in-person medical evaluation with the patient and may prescribe via telemedicine thereafter. The occurrence or frequency of additional in-person visits is not mandated under the Ryan Haight Act.

The Act also describes special circumstances such as “covering practitioners” – “a practitioner who conducts a medical evaluation [by telemedicine] at the request of a practitioner who … has conducted at least 1 in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine within the previous 24 months" – and prescribing within a federal health care system (e.g. Indian Health System; Department of Veteran’s Affairs).

Additional in-person evaluations, beyond the minimum required by relevant facility, state, and federal policy, is up to clinical discretion. For example, if the practitioner is unable to obtain the data they need for clinical decision-making through telehealth, the practitioner may recommend that a patient be seen in-person.

*For more information, visit the following links*

- https://www.congress.gov/110/plaws/publ425/PLAW-110publ425.pdf
- https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/prescribing-controlled-substances-via-telehealth

## DEFINITION OF CONTROLLED SUBSTANCE SCHEDULES

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. Some examples of the drugs in each schedule are listed below.

### SCHEDULE I CONTROLLED SUBSTANCES

Substances in this schedule have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Some examples of substances listed in Schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("Ecstasy").

**SCHEDULE II/IIN CONTROLLED SUBSTANCES (2/2N)**

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.

Examples of Schedule IIN stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).

Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.

**SCHEDULE III/IIIN CONTROLLED SUBSTANCES (3/3N)**

Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

Examples of Schedule III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

Examples of Schedule IIIN non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.

**SCHEDULE IV CONTROLLED SUBSTANCES**

Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

**SCHEDULE V CONTROLLED SUBSTANCES**

Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

Examples of Schedule V substances include: cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, Phenergan with Codeine®), and ezogabine.

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## FOLLOW-UP POLICIES

**IN COMPLIANCE WITH STATE LAW, NO SCHEDULE I, II, III, IV, OR V MEDICATION WILL BE PRESCRIBED UNTIL YOU'VE BEEN SEEN IN-PERSON AT LEAST ONCE.**

**NO SERVICES WILL BE PROVIDED UNTIL PAYMENT IS MADE IN FULL. NO EXCEPTIONS.**

**IF YOU ARE SEEING ME FOR PSYCHOTHERAPY ONLY**

- You agree to contact me for any emergency or crisis, unless it is medication related. If the emergency or crisis is related to medication, you agree to contact the provider who is prescribing the medication first. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.
- You agree to inform me if you are considering stopping therapy, or have actually stopped
- You agree to see me in person or via telemedicine video conferencing as you prefer. There is no follow up requirement if you are seeing me for psychotherapy ONLY.

**I RESERVE THE RIGHT TO STOP OR DISCONTINUE PRESCRIBING ANY MEDICATION(S) FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:**

- The policies outlined above are violated
- Based on my professional and clinical judgement, there is a medical or psychiatric contraindication that necessitates stopping or discontinuing any medication(s)
- Continuing any medication(s) pose(s) a significant risk to your physical or mental health that is not outweighed by potential benefits.
- Based on my professional and clinical judgement, there is suspicion of abuse or diversion of medications prescribed for you.

**I RESERVE THE RIGHT TO DISCONTINUE OR TERMINATE CARE FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:**

- The policies outlined above are violated
- Violation(s) of the Payment Policy Agreement (see below)
- Lack of adherence in treatment which, in my clinical judgement, poses a medical or psychiatric danger necessitating termination of care and/or referral to another provider(s)
- Inappropriate conduct, abuse, or harassment
- Appointments are repeatedly rescheduled, canceled, or you do not attend appointments.
- It has been over 12 months since you've been seen by Dr. Ingram.

***NOTE:*** *If care is terminated by Dr. Ingram, you will be provided with enough psychotropic medication, if applicable, to last no more than thirty (30) days. It will be your responsibility to find a new provider.*

## RISKS AND BENEFITS OF PSYCHOTHERAPY

Psychotherapy has both risks and benefits.

- Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events.
- Potential benefits include a reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolution of specific problems.
- Given the nature of psychotherapy, it remains an inexact science and no guarantees can be made regarding the outcome.

## CONFIDENTIALITY

**There is no guarantee of confidentiality under the following conditions:**

- If I suspect you are in imminent danger of harm to self or others, or a child or elderly person is being abused or neglected (as I am a mandated reporter).
- If a court orders a release of information
- If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
- If you pay by credit card, my name will appear on your credit card statement
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collections agency or other responsible party
- Between me and my administrative staff
- With your written permission only: between colleagues with whom I consult professionally.
- If you use text messaging or email to contact Dr. Ingram or his Administrative Assistant which is NOT a HIPAA Compliant means of communication
- If you call Dr. Ingram or his Administrative Assistant by phone which is NOT a HIPAA Compliant means of communication

## SCHEDULING APPOINTMENTS

Please be sure to schedule a follow up visit in advanced. Last minute appointment requests may not be fulfilled as appointment slots fill up quickly. In the event of an emergency or crisis, you are instructed to go to the nearest emergency room and/or call 911 immediately.

## NO SURPRISE BILLING STATEMENT

**DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE**

Dr. Michael Ingram isn't in your health plan's network. This means Dr. Michael Ingram doesn't have an agreement with your plan. The purpose of this statement is to let you know about your protections from unexpected medical bills. Receiving care from Dr. Michael Ingram could cost you more.

**If your plan covers the item or service you're getting, federal law protects you from higher bills:**

- When you get emergency care from out-of-network providers and facilities, or

- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

**If you sign this form, you may pay more because:**

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

**UNDERSTANDING YOUR OPTIONS**

You are always welcome to receive care from other providers who are in-network with your health plan. Please contact your insurance company for a list of providers in-network. For more information about your rights and protections, please visit https://www.cms.gov for more information about your rights under federal law.

## OPEN PAYMENTS DATABASE & ASSEMBLY BILL 1278

Pursuant to Assembly Bill (AB) 1278, physicians are required to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov .

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here (https://openpaymentsdata.cms.gov). The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

## STATEMENT ON DIAGNOSIS IN PSYCHIATRY

While a thorough diagnostic evaluation at the initial consultation visit provides Dr. Ingram with enough information to make one or more "provisional" diagnoses, it is important to remember that accurate diagnoses in psychiatric medicine develop over time (i.e., weeks to months) as Dr. Ingram gets to know his patients and their behavioral patterns. When appropriate, diagnoses will be given but should be viewed as provisional and subject to change. That is, diagnoses can evolve and change over time as new symptoms and patterns emerge. Dr. Ingram is primarily concerned with each individual's unique experience given that diagnoses do not adequately describe the complexity of a human being.

**NOTICE TO PATIENTS**

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, go to www.mbc.ca.gov or email licensecheck@mbc.ca.gov or call (800) 633-2322.

MTI PSYCHIATRY

## Acknowledgment and Consent

I, the undersigned, have read and understand the practice policies of Michael T. Ingram Psychiatry, Inc and I agree to adhere to these policies during my treatment.

I, the undersigned, understand that I can end this agreement by notifying Michael T. Ingram Psychiatry, Inc in writing before receiving services.

I, the undersigned, understand that I do not have to sign this form. But if I do not sign, Dr. Michael Ingram will not treat me.

I, the undersigned, understand that I am always welcome to receive care from a provider or facility in my health plan's network.

I, the undersigned, understand that it is unethical to receive psychiatric services from two different psychiatrists at the same time and that doing so without informing Dr. Michael Ingram will result in immediate termination of care.

I, the undersigned, acknowledge that I am consenting of my own free will and I am not being coerced or pressured.

| PATIENT SIGNATURE | | DATE |
|---|---|---|
| | | |

| GUARDIAN/REPRESENTATIVE SIGNATURE<br>*(If applicable)* | RELATIONSHIP TO PATIENT | DATE |
|---|---|---|
| | | |

MTI PSYCHIATRY

| MICHAEL T. INGRAM, MD | A145363 (California) | PSYCHIATRY |
|---|---|---|
| **PROVIDER NAME** | **LICENSE NUMBER** | **SPECIALTY** |

# GENERAL CONSENT FOR TREATMENT

- I am aware that the practice of medicine, especially Psychiatry, is not an exact science.
- I understand that no guarantee has been or can be made as to the results of the treatments or examinations provided by the healthcare provider named above.
- I voluntarily consent to participate in a diagnostic evaluation conducted by the healthcare provider named above.
- I agree to be contacted via email, phone, or Luminello EMR messaging system with information related to my visit, like: a patient portal invitation, medication and lab orders, requests to fill out forms, financial or payment information, pre-visit surveys, post-visit surveys, or appointment reminders.
- I consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment, and health care operations consistent with both the Notice of Privacy Practices and Payment Policy provided by the healthcare provider named above.
- I have either received a copy of the Notice of Privacy Practices or I have been provided easy access to the Notice of Privacy Practices.
- I have either received a copy of the Payment Policy Agreement or I have been provided easy access to the Payment Policy Agreement.
- I have either received a copy of the general practice policies or I have been provided easy access to the general practice policies.
- I give permission to obtain all my medication/prescription history, psychiatric history, medical history, and surgical history when using an electronic system to process prescriptions for my medical treatment.

*By signing this form, I hereby give my informed consent to receive medical care from the provider named above.*

| **PATIENT NAME (PRINT)** | **PATIENT SIGNATURE** | **DATE** |
|---|---|---|

| **GUARDIAN/REPRESENTATIVE SIGNATURE** *(If applicable)* | **RELATIONSHIP TO PATIENT** | **DATE** |
|---|---|---|


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# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

**PATIENT HEALTH INFORMATION (PHI)**

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information.

Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

**HOW WE USE YOUR PATIENT HEALTH INFORMATION (PHI)**

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

**Treatment:** We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

**Payment:** We will use and disclose your PHI for payment purposes. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

**Operation:** We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

**Special Situations that DO NOT require your permission:** We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

**Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

**INDIVIDUAL RIGHTS**

**You have certain rights regarding your PHI, for example:**

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any

other person that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address. In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

**OUR LEGAL DUTY**

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the patient portal on Luminello (Electronic Medical Record System). You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

MTI PSYCHIATRY

*Please sign your full name below to acknowledge that you have read all pages of this NOTICE OF PRIVACY PRACTICES form, that you understand this form, and that you agree with the contents of this form.*

| PATIENT NAME (PRINT) | PATIENT SIGNATURE | DATE |
|---|---|---|

| GUARDIAN/REPRESENTATIVE SIGNATURE *(If applicable)* | RELATIONSHIP TO PATIENT | DATE |
|---|---|---|

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MTI PSYCHIATRY

# PAYMENT INFORMATION FORM

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH |
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| ADDRESS | PHONE NUMBER |
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## CREDIT CARD | DEBIT CARD INFORMATION

Please complete all fields. You may cancel this authorization at any time by contacting our office. This authorization will remain in effect until it is cancelled. Your Credit Card or Debit Card information is kept in your secure Luminello patient portal for the entire duration of treatment. Unless other arrangements have been made, your credit card or debit card will be charged for the initial consultation, each appointment, administrative work, and cancellation/no show fees.

| | | | | | |
|---|---|---|---|---|---|
| **CHOOSE ONE:** | ☐CREDIT CARD | | ☐DEBIT CARD | | |
| **CHOOSE ONE:** | ☐VISA | ☐MASTERCARD | ☐AMEX | ☐DISCOVER | ☐OTHER |
| **NAME ON CARD:** | | | | | |
| **CARD NUMBER:** | | | **EXPIRATION DATE:** | | |
| | | | | | *MM/YYYY* |
| **CVV:** | | | | | |
| | *THREE- OR FOUR-DIGIT NUMBER ON BACK/FRONT OF CARD* | | | | |
| **BILLING ADDRESS:** | | | | | |
| | *Street* | *City* | *State* | *Zip* | *Country* |

I, the undersigned, authorize MTI Psychiatry, Inc. to charge the payment method provided above for all services rendered as outlined in the PAYMENT POLICY AGREEMENT. I understand that it is my responsibility to notify MTI Psychiatry, Inc. of any changes to my payment information. If my account becomes delinquent, I understand that I may be responsible for additional fees, including collection costs and legal fees. I understand that my information will be saved for future transactions. I have read and I understand all the rates and fees outlined in the PAYMENT POLICY AGREEMENT. I affirm I am an authorized user of the payment method indicated above.

| PATIENT SIGNATURE | DATE |
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| GUARDIAN/REPRESENTATIVE SIGNATURE *(If applicable)* | RELATIONSHIP TO PATIENT | DATE |
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MTI PSYCHIATRY

# PAYMENT POLICY AGREEMENT

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH |
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| ADDRESS | PHONE NUMBER |
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## PAYMENT POLICIES

This Payment Policy Agreement is designed to help Dr. Ingram provide the most efficient and reasonable health care services. Therefore, it is necessary to have a Payment Policy Agreement stating Dr. Ingram's requirements for payment for services provided to patients.

**DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE**

You agree to pay for services and fees as outlined in this PAYMENT POLICY AGREEMENT section. You are responsible for full payment, whether your insurance company ends up paying partially, or not at all, for services rendered. I do not communicate with insurance companies directly.

**YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT:**

- Insurance pays for any services
- We decide to proceed with treatment
- Treatment is successful, for which there cannot be any guarantee

Dr. Ingram is considered an "Out-of-Network" Provider. Some insurance companies will pay for services from "Out-of-Network" Providers, but there is no guarantee that your insurance company will pay for services. You are responsible for paying the total amount billed for each session, regardless of whether your insurance company pays. Dr. Ingram does not accept Medicare or Medi-Cal as forms of payment (Non-Participating Provider).

Furthermore, Dr. Ingram is not responsible for any communication with insurance companies. This includes, but is not limited to, generating insurance claims, disputing reimbursements, or completing prior authorization forms for medications, laboratory studies, or other diagnostic studies recommended by Dr. Ingram. You will be able to generate an insurance claim for yourself through Luminello, Inc., the electronic medical record (EMR) system used by Dr. Ingram. If needed, Luminello

has a user- guide to help you generate an insurance claim that you can submit to your insurance company.

There is no guarantee that your insurance company will reimburse you for the services provided by Dr. Ingram. You will be considered a self-pay patient during the entire course of treatment with Dr. Ingram.

Payment is due at the time of your scheduled appointment. No services will be provided until payment is received.

## RATES

| DESCRIPTION | LOCATION | DURATION | RATE |
|---|---|---|---|
| **Initial Consultation Visit** | Telemedicine or In-Office | 90 Minutes | **$1,200.00** |
| **Follow Up Visit** | Telemedicine or In-Office | 45 Minutes | **$500.00** |
| **Follow Up Visit** | Telemedicine or In-Office | 25 Minutes | **$350.00** |
| **Follow Up Visit** | Telemedicine Only | 15 Minutes | **$275.00** |
| **Phone Calls, Conference Calls outside a scheduled visit** | Telephone | -- | **$10.00 per minute** |

*At-home (in-person) visits are available upon request. Rates are doubled for at-home visits.*

**ALL IN-OFFICE VISITS ARE 25 MINUTES OR 45 MINUTES**

*Unless other arrangements have been made, the rates above apply.*

## PHONE CALLS, TEXT MESSAGES, PAPER WORK, AND ADMINISTRATIVE WORK

All phone calls and/or paperwork requested outside of your scheduled appointment will be charged at the rate indicated above. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

## LUMINELLO MESSAGING

Messaging Dr. Ingram directly via Luminello messaging will remain free of charge. If you have questions that cannot be answered in a quick response, please schedule a follow up visit by phone or telemedicine using the online scheduling tool or by calling/texting Dr. Ingram's Administrative Assistant at 949-436-9099.

## PROFILE INFORMATION AND CREDIT CARD/DEBIT CARD INFORMATION

Please be sure to keep your profile up to date. If you have a change of address, email, insurance, phone number, or emergency contact, please update this in your Luminello profile. An up-to-date Credit Card or Debit Card is required at all times. Please keep this updated by using the "billing" tab within your portal.

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The rates (prices) listed above will not change for the first 12 months of treatment, which begins on the day of your initial consultation visit and ends exactly 12 months after the day of your initial consultation visit. After the initial 12 months of treatment, rates (prices) for services may increase. You always have the option of discontinuing treatment with Dr. Ingram at any time and he will offer you referrals upon request.

***NOTE:*** *If it has been over 12 months since you've been seen for a follow up visit, then another consultation visit will be required to continue receiving treatment from Dr. Ingram.*

## ACCEPTED METHODS OF PAYMENT

- ✓ Cash
- ✓ Personal Check or Money Order
- ✓ Venmo
- ✓ Zelle
- ✓ Credit Card
- ✓ Debit Card

As you know, it is Dr. Ingram's policy to receive payment prior to your scheduled visit. No services will be provided until payment is received. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you receive the healthcare you deserve.

## GENERATING A BILLING STATEMENT

You can generate your own insurance claim to submit to your insurance company for reimbursement by going to "Billing" and "Create Statement". If needed, we are happy to do this for you and send it to you as a PDF.

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## SUMMARY OF POTENTIAL FEES

### WHAT ARE ALL THE POTENTIAL FEES YOU COULD INCUR DURING TREATMENT WITH DR. INGRAM?

- **CANCELLATIONS/NO SHOWS:** Not showing up to a scheduled appointment AND/OR canceling an appointment within 48 hours of your scheduled follow up appointment will result in your credit card or debit card being charged for the full rate/fee of the visit. If you are running late, please notify us immediately. If you are more than 10 minutes late to your scheduled appointment time, then your appointment may be canceled, and you will be charged for the full rate/fee of the visit.
- **SCHEDULED APPOINTMENTS:** Appointments are charged based on duration. Rates for appointments are listed above.
- **ADMINISTRATIVE WORK:** All phone calls and/or paperwork requested outside of your scheduled appointment will be charged at a the rate indicated above. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

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## Acknowledgment and Consent

I, the undersigned, have read and understand this Payment Policy Agreement and I agree to its terms and conditions including all rates and fees.

I, the undersigned, understand that I am responsible for payment of all services rendered even if insurance does not reimburse for services provided by Michael T. Ingram Psychiatry, Inc.

I, the undersigned, understand that I will be asked to pay in full for the services provided by Michael T. Ingram Psychiatry, Inc.

I, the undersigned, understand that I am giving up some consumer billing protections under federal law.

I, the undersigned, understand that I was given a written notice explaining that Dr. Michael Ingram is not in any health plans network, the estimated cost of services, and what I may owe if I agree to be treated by Dr. Michael Ingram.

I, the undersigned, understand that some or all amounts I make for services provided by Michael T. Ingram Psychiatry, Inc. may not count toward my health plan's deductible or out-of-pocket limit.

| **PATIENT SIGNATURE** | | **DATE** |
|---|---|---|
| | | |

| **GUARDIAN/REPRESENTATIVE SIGNATURE** *(If applicable)* | **RELATIONSHIP TO PATIENT** | **DATE** |
|---|---|---|
| | | |

8271 Melrose Ave, STE 110, Los Angeles, CA 90046
627 N Larchmont Blvd, Los Angeles, CA 90004

949-436-9099

mingram@mtipsychiatry.com

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# RELEASE OF INFORMATION FORM

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH |
|---|---|
| ADDRESS | PHONE NUMBER |

By signing below, I, the patient, hereby authorize and agree that Dr. Michael Ingram and MTI Psychiatry, Inc. may discuss and/or disseminate my personal health information (PHI) to, and receive that information from, the following individuals and/or entities: (if none, write “none”)

| | |
|---|---|
| | |
| | |
| | |

Specify what information Dr. Michael Ingram and MTI Psychiatry, Inc. may disclose, receive, share, and/or discuss with the individuals or entities identified above by checking the corresponding boxes below.

| | |
|---|---|
| ☐ **All health information** | ☐ **Progress notes** |
| ☐ **Consultation reports** | ☐ **Diagnostic test reports** |
| ☐ **History/physical exam** | ☐ **EKG/cardiology reports** |
| ☐ **Mental health records** | ☐ **Lab results** |
| ☐ **Past/present medications** | ☐ **Radiology reports and images** |
| ☐ **Patient allergies** | ☐ **Billing information** |

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I, the undersigned, understand I may revoke this authorization at any time by providing written notice to Dr. Michael Ingram. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless previously revoked in writing, this consent will terminate in 60 days following the completion of services.

I, the undersigned, understand that authorizing the disclosure of information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, that the information may not be protected by federal confidentiality rules, and that Dr. Michael Ingram and MTI Psychiatry Inc., are not liable for any such redisclosure. Finally, I understand that Dr. Michael Ingram may refuse to share my information with the authorized individuals/entities named above if, in Dr. Michael Ingram's discretion, doing so would not be in my best interest. If I have questions about disclosure of my information, I can contact Dr. Michael Ingram and/or MTI Psychiatry, Inc.

I, the undersigned, have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand and accept the terms and conditions of this authorization.

| **PATIENT SIGNATURE** | **DATE** |
|---|---|

| **GUARDIAN/REPRESENTATIVE SIGNATURE** *(If applicable)* | **RELATIONSHIP TO PATIENT** | **DATE** |
|---|---|---|

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# TELEMEDICINE/TELEHEALTH CONSENT FORM

## PATIENT INFORMATION

| PATIENT NAME | DATE OF BIRTH |
|---|---|
| ADDRESS | PHONE NUMBER |

This consent is for all telehealth services provided to me by Dr. Michael T. Ingram (my "Healthcare Provider").

Telehealth is the use of the Internet to provide remote health care for patients. Such care may come from doctors, nurses, mental health providers, and professional health educators.

Specifically, a health care professional will be communicating with me remotely via the Internet using any of the following platforms/software:

- Doxy.me, a web-based audio-video software. Doxy.me only hosts the software and does not provide medical advice or information.
- Zoom
- Doximity Dialer

Telehealth appointments may be for diagnosis, continuity of care, treatment, testing, or medical consultation deemed necessary by my Healthcare Provider or me.

**I understand that during a Telehealth Appointment**

- details of my medical history and personal health information may be discussed with me and/or other health professionals;
- audio, video, or photo recordings containing medical details may be transmitted via secure channels and those details may become part of my permanent medical record;
- all confidentiality protections granted to me by various state and federal laws also apply to my care during this appointment;

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- industry-standard network and software security protocols are in place that protect the privacy of the communication and safeguard my transmitted information against eavesdropping and corruption;
- there may be security and privacy risks associated with Internet-based communications;
- there are benefits and limitations when compared to a traditional in-person visit due to the fact that I will not be in the same room as my healthcare provider;
- either my Healthcare Provider or I can discontinue the use of Telehealth if either of us feels that the information obtained through remote communications is not adequate for diagnostic decision-making or for providing the care I desire;
- in addition to my Healthcare Provider named above, I will be informed of any other person(s) who may be present during the appointment and have the right to have them leave the viewing and listening area;
- to maintain my privacy, I need to ensure that my viewing and listening area is limited to myself and any other person that has a need to participate during the virtual appointment;
- due to the limitations of telehealth that are out of my control (such as an unreliable internet connection). I will call local authorities (9-1-1) to assist me with a medical emergency;
- I have the right to omit or withhold specific details of my medical history/physical examination that are personally sensitive;
- my Healthcare Provider may advise me to seek immediate treatment or determine that there is a medical emergency and, as such, local authorities may be given my personal details to assist me;
- the communication is privileged and confidential, and I will not record the audio or video without first seeking the permission of my Healthcare Provider.

**THEREFORE, BY CONSENTING TO THE USE OF TELEHEALTH:**

- I desire to engage in remote audio-visual communication with my Healthcare Provider.
- I understand the risks and benefits of using Internet-based communications and that no results can be guaranteed.

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- I acknowledge that if the Healthcare Provider believes that remote communication is insufficient for treatment, consultation, or evaluation, then I will be offered alternate services or options.
- I understand that I may be responsible for co-payments, deductibles, or other charges from my Healthcare Provider, and additional charges may occur for services related to this appointment.
- I understand that some parts of the exam involving physical tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Healthcare Provider.
- I have the ability to ask direct questions to my Healthcare Provider about telehealth appointments including details about the Healthcare Provider's privacy policy.
- If my questions are not answered to my satisfaction, I have the right to terminate the use of telehealth.
- I am at least 18 years of age or I will be in the presence of a guardian, parent, or legal representative at least 18 years of age.

**I, the undersigned, authorize Dr. Michael Ingram to use telehealth throughout my diagnosis and treatment.**

| **PATIENT SIGNATURE** | **DATE** |
|---|---|
| | |

| **GUARDIAN/REPRESENTATIVE SIGNATURE** *(If applicable)* | **RELATIONSHIP TO PATIENT** | **DATE** |
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