ALASKA PSYCHIATRIC CONCEPTS

DAVID B. ROBINSON, M.D., M.P.H.
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY
IN CHILD, ADOLESCENT AND ADULT PSYCHIATRY

WELCOME - PLEASE CAREFULLY REVIEW THE FOLLOWING, GATHER INFO AND ENDORSE THE **OFFICE POLICIES**:

I. PLEASE **GATHER OR REQUEST COPIES OF**: PREVIOUS MENTAL HEALTH OR **PSYCHIATRIC CARE** (INPATIENT OR OUTPATIENT); ROUTINE MEDICAL OR PEDIATRIC RECORDS INCLUDING RECENT (3-6 MONTHS) PHYSICAL EXAM, LABORATORY TESTS, NEUROIMAGING STUDIES, AND **MEDICATIONS INCLUDING DOSAGES**; CHILD CUSTODY OR GUARDIANSHIP DOCUMENTS; SCHOOL RECORDS (ACADEMIC OR PSYCHOLOGICAL TESTING, INDIVIDUALIZED EDUCATIONAL PLANS, SPECIAL ACCOMMODATIONS, REPORT CARDS); A LIST OF ALL OVER-THE-COUNTER MEDICINES, NUTRITIONAL SUPPLEMENTS AND ALTERNATIVE REMEDIES… **PRIOR TO THE FIRST APPOINTMENT.**

II. PLEASE **READ THE PRACTICE INFORMATION MATERIALS AND ENDORSE THE OFFICE POLICIES BELOW**. FEEL FREE TO ASK IF YOU HAVE ANY QUESTIONS.

1. **CANCELLATION POLICY (APPLIES TO "NO-SHOWS" OR FAILED APPOINTMENTS *AND* LATE CANCELLATIONS)**: BECAUSE OF THE LENGTH OF OUR APPOINTMENTS AND THE TIME USUALLY REQUIRED TO CONTACT OTHER PATIENTS, I DO NOT "DOUBLE BOOK" PATIENTS AND CAN RARELY FILL IN FAILED APPOINTMENTS ON SHORT NOTICE. FOR THESE REASONS PATIENTS / RESPONSIBLE PARTIES MUST PAY THE **FULL FEE** FOR SCHEDULED APPOINTMENTS IF THEY DO NOT PROVIDE **AT LEAST TWO FULL BUSINESS DAYS' (48 HOURS) NOTICE OF CANCELLATION,** OR A NOTE FROM A PHYSICIAN DOCUMENTING TREATMENT RECEIVED FOR **A MEDICAL EMERGENCY**. FOR EXAMPLE, ***THIS MEANS THAT NOTICE TO CANCEL A 9AM MONDAY APPOINTMENT MUST BE RECEIVED BY 9AM THE PRECEDING THURSDAY OR 9AM OF THE LAST BUSINESS DAY PRIOR TO THAT THURSDAY IF A HOLIDAY IS INVOLVED.*** PLEASE NOTE THAT INSURANCE COMPANIES WILL NOT PAY FOR MISSED APPOINTMENTS OR LATE CANCELLATIONS**.** ALSO, THE RESPONSIBLE PARTY SIGNING BELOW (PARENT, GUARDIAN, AGENCY OR OTHER ENTITY) IS RESPONSIBLE FOR THE ATTENDANCE OF ADOLESCENTS. **RESPONSIBLE PARTIES ARE ENCOURAGED TO ATTEND APPOINTMENTS EVEN IF THE ADOLESCENT MAKES HIM / HERSELF UNAVAILABLE AT THE LAST MINUTE,** TO AVOID THE NO-SHOW FEE.

2. **FEES MAY NOT BE REIMBURSABLE**: **PATIENTS ARE RESPONSIBLE FOR PAYING FOR SERVICES IN FULL AT THE TIME OF THE APPOINTMENT**, AND FOR FILING ANY CLAIMS TO OBTAIN INSURANCE REIMBURSEMENT, USING THE RECEIPT PROVIDED.

3. **ADDITIONAL SERVICES OUTSIDE YOUR SCHEDULED APPOINTMENT TIME: FEES ARE CHARGED** FOR ANY SERVICES RENDERED APART FROM YOUR APPOINTMENT TIME **IN EXCESS OF FIVE MINUTES.** EXAMPLES INCLUDE: **REVIEW OF MEDICAL RECORDS**, ASSISTANCE WITH **PRE-CERTIFICATION** OR **PRIOR AUTHORIZATION** OF CARE (IF NOT DONE DURING AN APPOINTMENT), PROVISION OF INFORMATION RE: A DISABILITY CLAIM, **REVIEW AND DOCUMENTATION** OF TREATMENT-RELATED REQUESTS OR INFORMATION BY PHONE, TEXT OR EMAIL **(**INCLUDING **PRESCRIPTION RESPONSES, ADJUSTMENTS, OR REFILLS BETWEEN SCHEDULED APPOINTMENTS**), AND **COORDINATION OF CARE** WITH OTHER PROFESSIONALS. THE RESPONSIBLE PARTY MUST AGREE TO PAY FOR THESE SERVICES WHEN RENDERED VIA ELECTRONIC PAYMENT OR RETAINER ON FILE.

4. **FORENSIC CONSULTATION AND EXPERT WITNESS TESTIMONY** ARE NOT CLINICAL TREATMENT SERVICES WITHIN THE SCOPE OF THE DOCTOR-PATIENT RELATIONSHIP. IF YOU ARE SEEKING THESE SERVICES, HAVE YOUR ATTORNEY CONTACT ME TO DISCUSS THE NECESSARY PROTOCOL. **I DO NOT PROVIDE CHILD CUSTODY INVESTIGATIONS OR EVALUATIONS.**

5. **TREATING PHYSICIAN**: IF YOU ANTICIPATE OR ARE INVOLVED IN LITIGATION SUCH AS A CHILD CUSTODY DISPUTE, OR IF ONE ARISES DURING TREATMENT, YOU WILL NEED TO SEEK THE SERVICES OF A FORENSIC SPECIALIST OR CUSTODY INVESTIGATOR. THE RESPONSIBLE PARTY SIGNING BELOW MUST AGREE TO PAY **ANY AND ALL COSTS ARISING FROM ANY AGREEMENT TO TESTIFY OR TO RESPOND TO A SUBPOENA** FROM ANY ATTORNEY OR COURT ATTEMPTING TO COMPEL MY TESTIMONY AS THE TREATING PHYSICIAN.

WITH MY SIGNATURE, I ATTEST THAT I HAVE READ, UNDERSTOOD AND AGREE TO ACCEPT THESE *OFFICE POLICIES* IN FULL AS A CONDITION OF CONSULTATION, EVALUATION AND / OR ONGOING TREATMENT.

____ ______________

SIGNATURE OF PATIENT / RESPONSIBLE PARTY DATE

III. **AUTHORIZATION FOR TREATMENT OF A MINOR**: AS PARENT OR GUARDIAN, I AUTHORIZE DAVID B. ROBINSON, M.D. TO PROVIDE MEDICAL / PSYCHIATRIC SERVICES FOR MY CHILD,

_______________________________________ ____________________________________ ___________

CHILD'S FULL NAME **SIGNATURE OF PARENT / GUARDIAN** DATE

2239 JORDAN AVENUE, JUNEAU, ALASKA 99801
MAIL: P.O. BOX 210411, AUKE BAY, ALASKA 99821
907-789-3800 // akpsycon@gci.net