RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

Welcome to RBE. In order to most efficiently use your face to face time with your clinician, we ask that you complete this form. This information will enable your clinician to understand and help you. If there are any questions you do not wish to answer, please draw a line through them and initial the item(s).

Adult Intake

Client's Name:_____ Clinician's Name: _____

Address: _____ City _____ State _____ Zip _____

Phone (H):_____ Phone (C):_____ Phone (Other):_____

Email:_____@_____

SSN: _____ DOB: _____ AGE: _____ Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Divorced & Remarried
☐ Coupled ☐ Separated ☐ Widowed

Ethnicity: ☐ Black, non-Hispanic origin ☐ Hispanic ☐ White, non-Hispanic origin
☐ American Indian/Alaskan Native ☐ Asian/Pacific Islander ☐ Other: _____

INSURANCE INFORMATION (MUST BE COMPLETED)

Person responsible for this account: _____ Relationship to Patient: _____

Address: _____ Phone: _____

Policy Holder's Name: _____ DOB: _____ SS#: _____

Employer: _____ Address: _____

Insurance Plan: _____

ID#: _____ Group #: _____

EMERGENCY CONTACT

Name: _____ Phone: _____

Relationship to you: _____

I give permission to my clinician or a staff member of Ramesh B. Eluri, MD, PC to contact the person listed above in case of an emergency.

Signature: _____ Date: _____

MEDICAL CONCERNS

Primary Care Doctor: _____Phone: _____ Fax: _____

Current Medical Concerns: _____

_____

_____

Surgical History: _____

_____

Chronic Medical Illnesses: _____

_____

_____

Allergies (including medication allergies): _____

_____

(Please continue to Page 2)

CURRENT PRESCRIPTION MEDICATION:

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____

PRESENTING PROBLEMS & CONCERNS

Please describe the problem that brought you here today: _____

_____

_____

Please check all of the behaviors and symptoms that you consider problematic or that you may want to address:

☐ Distractibility	☐ Change in appetite	☐ Suspicion/Paranoia	☐ Racing Thoughts
☐ Hyperactivity	☐ Lack of motivation	☐ Thoughts of death	☐ Excessive energy
☐ Impulsivity	☐ Withdrawal from people	☐ Self-harm behaviors	☐ Frequent arguments
☐ Boredom	☐ Anxiety/worry	☐ Crying spells	☐ Irritability/anger
☐ Poor Memory/Confusion	☐ Panic attacks	☐ Loneliness	☐ Homicidal thoughts
☐ Seasonal Mood Changes	☐ Fear away from home	☐ Low self-worth	☐ Flashbacks
☐ Sadness/Depression	☐ Social discomfort	☐ Guilt/shame	☐ Hearing voices
☐ Loss of pleasure/interest	☐ Obsessive thoughts	☐ Fatigue	☐ Visual hallucinations
☐ Sleep problems	☐ Nightmares	☐ Eating problems	☐ Gambling problems
☐ Computer addiction	☐ Parenting problems	☐ Sexual problems	☐ Problems with pornography
☐ Relationship problems	☐ Work/school problems	☐ Alcohol/drug use	☐ Recurring, disturbing memories

☐ Other: _____

Are your problems affecting any of the following?

☐ Handling everyday tasks	☐ Self-esteem	☐ Relationships	☐ Hygiene
☐ Work/School	☐ Housing	☐ Legal matters	☐ Finances
☐ Recreational activities	☐ Sexual activity	☐ Health	☐ Level of motivation

How long have you been dealing with the above symptoms? _____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt or kill yourself?

If yes, please describe: _____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt or kill someone else?

If yes, please describe: _____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else?

If yes, please describe: _____

What do you wish to accomplish through your treatment at RBE? _____

_____

_____

_____

This document contains information required by federal and state law. We know it's long, please bear with us, we've made it as short as we can!

RBE
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Psychiatry & Psychology Services

Client Information and Consent to Behavioral Health Treatment

Welcome to Ramesh B. Eluri, MD,PC (RBE). This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA). Although these documents are long and sometimes complex, it is very important that you read them carefully before our session. We can discuss any questions you have at that time. When you sign this document, it will also represent an agreement between us. You may revoke this agreement in writing at any time. That revocation will be binding on us unless we have 1) taken action in reliance on it; 2) if there are obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or 3) you have not satisfied financial obligations you have incurred.

BEHAVIORAL HEALTH SERVICES

Psychotherapy is not easily described in general statements. It varies depending on the personalities of the therapist and the patient, and the problems or concerns you are experiencing. There are many different methods we use to deal with the problems or concerns you hope to address. Psychotherapy is not like a medical visit. Instead, it calls for an active effort on your part. In order for therapy to be most successful, you will have to work on things we talk about during our sessions and at home.

Psychotherapy can have benefits and risks. Since it often involves discussing unpleasant aspects of your life, you may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness, or helplessness. On the other hand, psychotherapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and reductions in feelings of distress, but there are no guarantees of what you will experience. Being open about what you're experiencing is important and really depends on you, as the therapy experience is collaborative and changes can be made in most circumstances.

If you accept a referral for psychiatric services, treatment recommendations may include prescription medication. The Psychiatrist or Certified Registered Nurse Practitioner will discuss risks and benefits of any medication prescribed.

Prescriptions for medications and refills of medications will only be provided by a Psychiatrist or Nurse Practitioner at the time of the appointment. It is the discretion of the prescriber to determine if a refill will be provided between scheduled appointments. If a refill is provided by a prescriber without an appointment, another refill will not be provided until the next appointment. If you are in need of medication changes, you must be seen in the office. Please note that a fee may apply for refills provided outside of a scheduled appointment.

Narcotic/benzodiazepine prescriptions will not typically be prescribed by RBE unless an exception is made by the prescriber on an individual basis. Narcotic/benzodiazepine prescriptions will not be refilled early or replaced under any circumstances. If you are unable to schedule an appointment before your medication runs out, your prescriber may call in three (3) business days' worth of medication if an appointment to be seen in our office by any of our prescribers, is made within three (3) business days. If you are unable to make a face-to-face appointment within three (3) business days, we will not be able to make an electronic request or phone request for medication. All prescriptions for controlled substances will be photocopied and will become a part of your medical record. You will be asked to sign the copy to verify its receipt and accuracy.
If medication is stolen, a police report must be presented before a replacement prescription will be given. If a prescription is lost, it will be replaced at the discretion of the prescriber. All clients on medication must provide

a release of information for your primary care doctor for consultation purposes. Please note that physicals and lab work may be required. Refusal to comply with recommendations for physicals or lab work could lead to termination of services. Medication is often seen as an adjunct to therapy. It will be at the discretion of your treating prescriber whether medication management will be provided without ongoing therapy. If adjunctive therapy is recommended and the client does not agree/comply, medication management services could be terminated.

Our first therapy session will involve an evaluation of your needs. By the end of the evaluation, your therapist will be able to offer you some initial impressions of what your treatment will include and an initial treatment plan, if you decide to continue with therapy. In some cases, particularly with children, the initial evaluation will take several sessions. You should consider this information along with your own assessment about whether your therapist is a person with whom you feel comfortable working. Therapy involves a large commitment of time, money, and energy. If you have questions about your treatment, diagnosis, or sessions, you should discuss them with your therapist whenever they arise. If you are unable to discuss your concerns with your therapist, you may call and ask to speak with the Outpatient Clinical Manager.

APPOINTMENTS

After the initial intake, each therapy session will be approximately 45-50 minutes in length and medication appointments will be approximately 15-30 minutes in length. Please be aware that your provider will make every effort to be available to you at your appointment time. Because this time could have been available to another person, we will expect you to keep any appointment you make unless an emergency occurs or you give 24 hour notice. If you arrive more than 15 minutes after your scheduled appointment time, you may need to be rescheduled and will be assessed a "Missed Appointment" fee. Please refer to the Financial Policy Agreement for our financial policies and fees.

CONTACTING US

We maintain a voicemail system that is available to take your messages 24 hours a day. In most cases, non-urgent messages can be left on voicemail and will be picked up and returned within 24 hours Monday through Friday.

EMAIL/TEXT COMMUNICATIONS

Some of our therapists use email or texts for routine communication about appointments and other matters. **If you communicate with your therapist via email or text, please be aware that privacy and security are a complex issue and cannot be guaranteed at the same level as telephone or written messages.** As such, emails can be received by unintended recipients, backup copies of email may exist even after email is deleted, email senders can easily type in the wrong email address, etc.

For those therapists who use emails, emails will typically be used to discuss administrative issues such as appointments. Personal information should not be communicated using email. **Do not use email or texts for emergency communication.** We cannot guarantee that emails or texts will be monitored frequently. We recommend that you take precautions to protect the confidentiality of email, such as safeguarding your computer password and maintaining current recommended security features.

Emails (not including general practice information) will be part of your medical record. We will not release your email address to 3rd parties unless you consent for us to do so. Please refer to our Notice of Privacy Practices (HIPAA Notice) for information as to permitted uses of your health information and your rights regarding privacy matters. Patients will receive emails about information on general practice news, groups, seminars, workshops, and satisfaction surveys if indicated on their patient questionnaire.

_____
(Initial)

EMERGENCIES

Your therapist, prescriber, or someone else in our practice, will be available for emergency assistance during regular office hours (9AM to 5PM). From 5PM to 9AM, weekends, and major holidays, prescribers will be on call to respond to medication questions and concerns. When you call our voicemail system, follow the prompts for emergencies (Press 9), and you will be connected to our answering service. Please identify yourself as a patient of **Ramesh B. Eluri, MD,PC**.

If you are having any difficulty getting through to the appropriate person, or are unable to wait for a return call by a therapist (during office hours), or are in need of immediate assistance, please go to the nearest emergency room or call 9-1-1.

If you block anonymous calls, please turn off such blocking while you wait for a return call as we often return calls from confidential telephone numbers. Do not use email or texts for emergency communications.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed mental health professional. In most situations, we can only release information about your treatment to others if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this Agreement provides consent for those activities, as follows:

- We may occasionally find it helpful to consult other health and mental health professionals about a case. During a consultation, we make every effort to avoid revealing the identity of any patient. The other professionals are also legally bound to keep the information confidential. If you don't object, we will not tell you about these consultations unless we feel that it is important to our work together. We will note all consultations in your Clinical Record.
- You should be aware that we practice with other mental health professionals and that we employ administrative staff. In most cases, we need to share your protected information with these individuals for both clinical and administrative purposes, such as scheduling, billing, and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release information outside of the practice without the permission of a professional staff member. Even within RBE, only necessary information is shared. If more than one member of a family is in treatment here, therapists involved will share information only with your permission.
- We also have contracts with an answering service, computer services providers, and other vendors. As required by HIPAA, we have a formal business associate contract with these businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract. Again, only necessary information is shared.
- Disclosures required by health insurers are discussed elsewhere in this agreement.

The HIPAA Notice spells out situations where we are required to release information even without your consent. There are some situations, in addition to those included in the Notice where we are permitted or required to disclose information without either your consent or Authorization:

- If a government agency is requesting the information for health oversight activities, we may be required to provide it for them.
- If a patient files a complaint or lawsuit against us, we may disclose relevant information regarding that patient in order to defend ourselves.
- If we believe you are a danger to yourself or others, we will do whatever we need to do to protect you and others, including contacting your family, emergency services, or the police.

_____
(Initial)

- If we have reason to suspect, on the basis of our professional judgement, that a child is or has been abused, we are required to report our suspicions to the authority or government agency vested to conduct child abuse investigations. (Please see the HIPAA Notice for more details.)

Based on Act 147, passed by the Pennsylvania state legislature in 2005, it is RBE's policy that minors aged 14-17 control consents to release information, except that parents/legal guardians can consent to release of records to a primary care physician or a current mental health provider if we believe it is in the minor's best interest. Parents/legal guardians have the right to information necessary for providing consent, including: symptoms, conditions to be treated, medications, other treatments, risks, benefits, and expected results.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that you read the HIPAA Notice and we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex, and we are not attorneys. In situations where specific advice is required, legal advice may be needed.

As permitted by this law, this office may contact patients to notify them of future appointments or schedule changes by phone, text, or email or by leaving a voicemail message on provided numbers. When contacting a patient by phone, this office uses a standard practice of simply identifying ourselves as "your doctor's office." If you are a patient of a therapist, the therapist's name only (not title) would be used.

If you do not wish for this office to leave a message on your voicemail, you may indicate below. PLEASE NOTE: Although HIPAA regulations allow for reasonable use of voicemail messages, etc., this office will make every effort to respect your request.

Messages may be left at my residence:	☐Yes	☐No
Messages may be left on my cell phone:	☐Yes	☐No
Reminder emails may be sent:	☐Yes	☐No
Reminder text messages may be sent:	☐Yes	☐No

I grant permission for the following individuals to make or change appointments on my behalf:

_____

_____

Patient Signature (Parent/Guardian if applicable) Date

PROFESSIONAL RECORDS

The laws and standards of our professions require that we keep treatment records. You are entitled to receive a copy of the records unless we believe that seeing them would be emotionally damaging, in which case we will be happy to send them to a mental health professional of your choice. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. We recommend that you review them in the presence of your therapist so that the contents can be discussed. Patients will be charged an appropriate fee for any time spent in preparing information requests, and for the records themselves. If more than one person is seen in a session, both must consent to any release of the record.

CLIENT RIGHTS AND RESPONSIBILITIES

I have been given a copy of RBE's Client Rights and Responsibilities and am aware of the Grievance and Appeal Procedures. This policy is also posted in the waiting room. I am aware that I may request an additional copy of RBE's Client Rights and Responsibilities at any time.

_____
(Initial)

INSURANCE REIMBURSEMENT

You should be aware that your contract with your health insurance company requires that we provide it with information relevant to the services that we provide to you. We are required to provide a clinical diagnosis.

Sometimes we are required to provide additional clinical information such as treatment plans or summaries, or copies of your entire Clinical Record. In such situations, we will make every effort to release only the minimum information about you that is necessary for the purpose requested. Your health insurance company is required by state and federal law to maintain the privacy and security of any information we share with them. If you have questions about what your health insurance company does with the information that is disclosed to them, you may contact them to request a copy of their Notice of Privacy Practices. Increasingly, billing is electronic, rather than dependent on paper claim forms. We will provide you with a copy of any report we submit, if you request it. By signing this Agreement, you agree that we can provide requested information to your insurance provider.

TERMINATION OF SERVICES

You understand that treatment will end when the concerns for which you initially sought treatment are resolved. If progress is not made or there is a conflict in the working relationship between client and treatment provider, your provider can terminate treatment at any time. If treatment is terminated prematurely by the treatment provider, a referral will be given for continued treatment with another provider either at RBE or in the community. Your treatment provider may set boundaries including forms of client interactions and communication including ceasing to provide services to you for good cause, including without limitation: your refusal to comply with treatment recommendations, the undersigned treatment provider or staff member is uncomfortable working with you, or your failure to timely pay fees or deposits in accordance with this Information and Consent Form, subject to the professional responsibility requirements to which the undersigned treatment provider is subject. Inappropriate behavior including, but not limited to, yelling, violence, or threatening behavior will not be tolerated and could lead to termination of services, at the discretion of the treatment provider and RBE. Please note that if you do not show for 3 appointments, arrive more than 15 minutes after your scheduled appointment time on 3 occasions, or call to cancel 3 times less than 24 hours before that appointment, your services can be terminated.

ADDITIONAL CONSENT TO TREAT A MINOR

Therapy is most effective when a trusting relationship exists between therapist and patient. Privacy is especially important in securing and maintaining that trust. One goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop an expectation of privacy, whereby they feel comfortable discussing personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will acknowledge that we will provide your child with age-appropriate privacy and confidentiality.

It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed without your child's consent. We will tell you if your child does not attend sessions. We will share general information such as issues discussed, progress made, and what other areas are likely to require intervention in the future. The details will vary with the age of your child and the specific situation; your therapist will clarify these issues in the initial session(s). If your child is an adolescent, it is possibly that s/he will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Some of these behaviors may be minor problems, but at other times they may require parental intervention. Feel free to discuss with your therapist any concerns you have about how these issues will be addressed. If we ever believe that your child is a serious risk of harming him/herself or anyone else, we will inform you.

_____
(Initial)

The following is specific to potential custody or other legal disputes:
I am aware that requesting the release of treatment plans, notes, or reports in custody disputes, or subpoenaing testimony about any of the content of my child's treatment, interferes with the therapy relationship and may jeopardize any gains made in psychotherapy. Therapists must be able to be neutral in family legal conflicts to be helpful. I agree that the role of RBE is limited to providing treatment and that I will not involve RBE in legal disputes, especially a dispute concerning custody, custody arrangements, visitation, etc. Therefore, I knowingly and freely waive my right to request the release of information to myself or my attorney or any other Officer of the Court for such disputes. I agree to instruct my attorneys not to subpoena RBE or its staff, or to refer in any court filings to what RBE staff has said or done. Except for records of attendance and billing, I understand that release of clinically significant information shall be by Court Order, signed by a duly appointed Judge. If I share legal custody of my child and both parents consent to treatment and I decide to withdraw my consent against the other parent's wishes, I agree to 4 termination sessions if RBE staff believes it is in my child's best interest.

RBE will continue to release records to your child's physician for treatment purposes with the consent of one parent. If there is a court appointed evaluator in a custody dispute, and if appropriate releases are signed by both parents and a court order is provided, RBE will provide general information about the child which will not include recommendations concerning custody or custody arrangements. If for any reason, RBE staff are required to appear as a witness or speak to a custody evaluator or judge, time spent preparing reports, traveling, reviewing files, or other case-related costs will be charged at a non-insurance based rate to the party responsible.

SIGNATURE FOR CONSENT TO TREAT MINORS:

_____

Child's Name Parent or Guardian name Signature Date

FOR ALL CLIENTS:

Your initials at the bottom of each page of this document indicate that you understand the information presented on that page and that any related questions have been answered. Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

_____

Print Name (Relationship) Signature Date

_____
(Initial)

RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

FINANCIAL POLICY

Thank you for choosing us as your behavioral health provider. We are committed to providing you with quality care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it and ask us any questions you may have. Your signature indicates you have read and accepted our Financial Policies. A copy will be provided to you upon request.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will submit claims to insurance companies and provide you with whatever assistance we can in helping you receive the benefits to which you are entitled; however, you (not your insurance company) are responsible for full payment of our fees. It is very important that you find out exactly what mental health services your insurance policy covers. You should carefully read the section in your insurance coverage booklet that describes behavioral health services, including the maximum number of sessions per year. If you have questions about your coverage, call your plan administrator. Of course, we will provide you with whatever information we can based on our experience and will be happy to help you in understanding the information you receive from your insurance company.

1. **Insurance.** We participate in most commercial insurance plans. If you are not insured by a plan in which we participate, payment in full is expected at each visit. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full is expected at each visit until we can verify your coverage. **Knowing your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage. If your insurance company does not pay your claim, the balance will be your responsibility.

   Services provided by Psychology Technicians who are not paneled with your insurance company, may be billed under our Licensed Psychologist if the insurance company allows. If they do not allow this, I understand that this service is not eligible for submission to my insurance company; subsequently, we have agreed to a per session fee of $_____.

2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. We will give you our best estimate of what the co-pay should be for each visit. For many policies, the co-pay may change during your course of treatment and insurance plans change without notifying providers. The only way we can confirm exactly what a co-pay should have been is by reading the materials that come to us from the insurance company after the session is billed and paid. You may receive a copy of this Explanation of Benefits (EOB) from your insurance company. You If your co-pay was higher than collected, you are responsible for paying the difference. If it should have been lower, we will give you a refund or credit.

3. **Non-covered services.** Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by insurers. You must pay for these services at the time of service or within **14** days of the billing statement.

4. **Billing Statements.** Billing statements shall be deemed to be accepted by you unless RBE is notified in writing within 14 days of the statement being issued that you dispute the amount due. In the event of non-payment, RBE may in addition to the invoice amount charge:

   Interest on any outstanding amounts from the due date calculated at the statutory penalty rate of 6%.
   If any part of your account with RBE falls into arrears, then the totality of that account, whether in arrears or not in arrears, shall become immediately due and payable.

404 E. High Street
Pottstown, PA 19464
(484) 973-6661 □ F: (610) 323-6058

_____ (Initial)

5. **Proof of insurance.** All patients must complete our patient information form before seeing a clinician. We must obtain your driver's license (or another form of ID) and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claim.

6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

7. **Coverage changes.** If your insurance changes, please notify us before your next visit so that we can make the appropriate changes to help you receive your maximum benefits. If you fail to notify us of insurance changes in a timely manner, you may be responsible for your entire bill.

8. **Non-payment and Collections.** If your account is over **30** days past due, you will receive a letter stating that you have **14** days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid for **60** days, it is our right to refer your account to a collection agency authorized to credit report all outstanding debts to the four major National Credit Agencies and/or litigate in a court of law. You will be required to reimburse RBE any collection agency fees, which may be based on a percentage at a maximum of 30% of the debt, and all cost and expenses, including reasonable attorneys' fees, we incur in such collection efforts.

9. **Missed appointments.** We require **24-hour notice** if you need to cancel an appointment. You will be charged for any missed appointment or cancelled appointment (when 24-hour notice was not given). These charges will be your responsibility (insurance companies do not provide reimbursement for cancelled sessions) and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment or call **24** hours prior to your appointment.

   Missed appointment fees or when appointments are cancelled without 24-hour notice are as follows:

For appointments between the hours of 8:00 and 5PM Monday through Friday:	$40
For appointments Monday through Friday after 5PM:	$60
For appointments scheduled on Saturdays:	$75

10. **Other charges.**

Returned Check Charge	$50
Please note: *We will not accept additional checks if two are returned.* **Post-dated checks will not be accepted.**	
Prescription requests when follow-up appointments are not current:	$25
Please note: *You will be required to be seen in our office within 7 business days for any additional needed medication.*	
Completing forms (disability, life insurance, etc.)	$75-95 per hour
Varies by provider	
Copying records (except when sent to another health professional)	$Varies by Request
Preparation of letters	$75-95 per hour
Varies by provider	
Telephone Session	Varies by provider.

Our practice is committed to providing the best treatment to our patients. Our rates are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or responsible party Date

RBE
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CLIENTS' RIGHTS

- Clients have the right to receive full information about their therapist's knowledge, skills, preparation, experience, and credentials.
- Clients have the right to be informed about the options available for treatment interventions and the effectiveness of the recommended treatment.
- Clients have the right to fully participate in all decisions related to their health care. If unable to fully participate in decisions related to health care, the client may be represented by parents, guardians, or other family members.
- Clients have the right to make final decisions regarding the recommendations of the therapist.
- Clients have the right to change to an alternative therapist if they so choose.
- Clients have the right to pursue a second opinion.
- Clients have the right be involved in discharge planning from treatment beginning to termination.
- Clients have the right to submit complaints or grievances.
- Clients have the right to confidentiality. Any disclosure to another party will only be made with the knowing, written consent of the client and will be time limited, unless laws or ethics dictate otherwise. Entities receiving information for the purpose of benefits determination, public agencies receiving information for health care planning, or any other organization with legitimate right to information will maintain clinical information in confidence with the same rigor and be subject to the same penalties for violation as is the direct provider of care. All client information is treated as private and confidential.
- Clients have the right to considerate, respectful care. Quality mental health services shall be provided to all individuals without regard to race, ethnicity, nationality, religious belief, gender, age, sexual orientation, or disability.

CLIENTS' RESPONSIBILITIES

- Clients are responsible for providing accurate and complete information about all matters pertaining to your health, including medications and past or present medical and/or mental health problems.
- Clients are responsible to report changes in their condition or symptoms.
- Clients are responsible to identify and report any safety concerns that may affect your care.
- Clients are responsible to ask if you do not understand information about your care or treatment.
- Clients are responsible to inform their provider if unsatisfied with any aspect of their care.
- Clients are responsible to participate in the planning of their care, including termination and discharge planning.
- Clients are responsible to keep scheduled appointments and cancel appointments 24 hours in advance.
- Clients are responsible for full payment of services should insurance company not provide payment.
- Clients are responsible for their office co-pay or co-insurance as their benefits plan dictates.

Please maintain this page for your records.
Please note, additional requirements may vary by insurance carrier.

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Psychiatry & Psychology Services

AUTHORIZATION FORM

Patient Name: _____ Birthdate: _____

This form, when completed and signed by you, authorizes us to release protected health information from your clinical record to/from the person you designate.

I authorize _____ and/or his/her staff to

☐ Release to ☐ Receive from:

_____

_____

_____

_____

The following information (provide detailed description):

_____

_____

I am requesting to release this information for the following reasons ("at the request of the patient" is all that is required if you are the patient and you do not desire to state a specific purpose.):

_____

This authorization shall remain in effect for one year or until (fill in date or relevant event):

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Ramesh B. Eluri, MD.,PC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

☐I do not want a copy of this form. ☐ A copy of this form has been provided to me.

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian for a minor Date

Prohibition of Redisclosure: Confidential health care information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws, including HIPAA, prohibit you from making disclosures of this information unless further disclosure is expressly permitted by the written Authorization of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Revised 5/8/2008.

404 E. High Street
Pottstown, PA 19464
(484) 973-6661 □ F: (610) 323-6058

RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

Office Policies and Procedures Acknowledgement Form

Our Prescribers:

Ramesh Eluri, MD
Joyce Yablunsky, CRNP

Our Clinicians:

Erica Avello, Psy.D
Trish Hartman-Moyer, LCSW
Dolores Hill-Glenn, LCSW
Jessica Marks, LCSW
Mark Merryman, LCSW
Lauren Ostrowski, LPC
Tom Post, LPC
Stephanie Smith, LPC
Sandra Wiley, LCSW

In compliance with the Pennsylvania Board of Psychology, we are required to inform you that the following therapists are under psychological work supervision with Dr. Erica Avello:

Melanie Newman, MA……. Erica Avello, Psy.D

By my signature below, I agree to abide by the Office Policies and Procedures documents provided to me. I have received a statement of my rights and responsibilities and all documents required by HIPAA.

Received and Read: _____

Patient Signature (Or Parent/Guardian) Date

PREVIOUS MENTAL HEALTH TREATMENT

Have you previously been involved in mental health treatment? If yes, please describe. _____

_____

_____

Do you feel it was helpful? Why? _____

_____

_____

SUBSTANCE USE HISTORY (If applicable)

Substance Type		Current Use (last 6 months) Frequency/Amount		Past Use Frequency/Amount
Tobacco	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Caffeine	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Alcohol	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Marijuana	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Cocaine/Crack	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Ecstasy	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Heroin	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Inhalants	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Methamphetamines	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Pain Killers	☐Yes ☐ No	_____	☐Yes ☐ No	_____
PCP/LSD	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Steroids	☐Yes ☐ No	_____	☐Yes ☐ No	_____
Tranquilizers	☐Yes ☐ No	_____	☐Yes ☐ No	_____

☐Yes ☐ No Have you had withdrawal symptoms when trying to stop using any substances?
If yes, please describe: _____

☐Yes ☐ No Have you ever had problems with work, relationships, health, the law, etc. due to your substance use?
If yes, please describe: _____

FAMILY HISTORY

Briefly describe your childhood experience: _____

_____

_____

Relationship with parents/siblings as a child: _____

_____

_____

Describe your relationship with your family now: _____

_____

_____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse	☐ Neglect	☐ Homelessness	☐ Loss of a loved one
☐ Sexual abuse	☐ Violence in the home	☐ Lived in a foster home	☐ Financial problems
☐ Physical abuse	☐ Crime victim	☐ Multiple family moves	☐ Other event
☐ Parent substance abuse	☐ Parent illness	☐ Natural disaster (hurricane, flood, etc.)	

Has anyone in your family been diagnosed with mental illness? ☐Yes ☐ No
If yes, please explain: _____

_____

Are you currently in a relationship or married? ☐Yes ☐ No If yes, partner's name: _____

Number of marriages: _____ Number of divorces: _____ If widowed, your age at death of spouse: _____

Do you have any children?

Name	Age
_____	_____
_____	_____
_____	_____
_____	_____

Are you currently involved in any legal proceedings? ☐Yes ☐ No

If yes, is your treatment court ordered? ☐Yes ☐ No

If yes, please explain: _____

_____

_____

Are you currently involved in divorce or child custody proceedings? ☐Yes ☐ No

If yes, please explain: _____

_____

_____

SOCIAL & DEVELOPMENTAL HISTORY

Aside from yourself, who lives in your home?

Name	Relation to Yourself	Age	Occupation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

What is your relationship like with the members of your household? _____

_____

_____

Do you have other family members living in the area? _____

_____

Optional Question:

Do you have any cultural or spiritual beliefs that the clinician should be aware of? _____

_____

EMPLOYEMENT & EDUCATION

What best describes your current employment status (Check one from each category):

Employment Status:	Student Status:	Other:
☐ Unemployed, not looking for employment	☐ Part-time	_____
☐ Unemployed, looking for employment	☐ Full-time	_____
☐ Full-time employed	☐ Part-time employed	_____
☐ Retired ☐ Self-employed	☐ Not a student	
☐ Social Security Disability☐ Other: _____		

What is your occupation? _____

What is your highest degree obtained? _____

Where was your degree/diploma obtained? _____

RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

Ramesh B. Eluri, M.D., P.C.
Diplomat American Board
Psychiatry and Neurology
Adult and Geriatric Psychiatry
Suboxone Treatment,
Psychological Assessments
and Psychotherapy

Ramesh B. Eluri, MD

Joyce Yablunsky, CRNP

Trish Hartman-Moyer, LCSW

Dolores Hill-Glenn, LCSW

Tom Post, Jr, LPC

Stephanie Smith, LPC

Mark Walthofer, LCSW

Kristen Mullen, PA

Roxanne Jeffries-Baxter, CRNP

Chijioke Nwankwo, DNP,CRNP

Joshua Baker, CRNP

Shelle Savill, LCSW

Wanda Siller, LCSW

MEDICAL RECORDS RELEASE POLICY

In response to the Health Insurance and Portability Act (HIPPA) of 1996, Ramesh B. Eluri, MD, PC has developed policies and procedures to insure that confidential medical records are handled in a manner meeting all necessary guidelines.

Medical Records will be released only upon written request from the patient. Written requests must be in accordance with the Uniform Health Care Information Act. Only records created and maintained by our providers will be released. A records release form was signed in your Initial Evaluation Intake Packet. If needed, one can also be provided upon request.
Requirements for a valid authorization are:

- In writing, dated and signed by patient
- Specifically identifies patient
- Specifically identifies healthcare provider who is to make the disclosure
- Specifically identifies information to be disclosed

Please allow 5 to 10 business days for any records request to be processed.

Below is our records request fee schedule. Fees cover the costs of paper, postage and copier ink/supplies.

Comm. Of PA Bureau of Disability Request: $ 31.94 set fee

Patient Self Request/Other Physician Office: NO CHARGE

Any other type of request: Pages 1-20 $1.70/page
Pages 20-60 $1.26/page
Pages 61-end $ .44/page

Thank you.

Print Name_____

Signature_____
Date_____

404 E. High St
Pottstown, PA 19464
(P) 484-973-6661
(F) 610-323-6058

1555 W. Main St
Jeffersonville, PA 19403
(P) 610-631-3401
(F) 610-631-3408

www.elurimdpc.com

Human Services. The person listed above can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions and Changes to Privacy Policy

This notice will go into effect on April 14, 2022

I have received a copy of the HIPAA Privacy Notice Form.

Print Name (relationship if minor) Signature Date

extent possible, or (through a written authorization) designate a third party who may receive such information.

- *Right to Restrict Disclosures When You Have Paid for Your Care Out-of-Pocket (Self-Pay)-* You have the right to restrict certain disclosures of PHI to a health plan when you pay out-of-pocket in full for our services.
- *Right to be Notified if There is a Breach of Your Unsecured PHI-* You have a right to be notified if: (a) there is a breach (a use or disclosure of your PHI in violation of the HIPAA Privacy Rule) involving your PHI; (b) that PHI has not been encrypted to government standards; and (c) our risk assessment fails to determine that there is a low probability that your PHI has been compromised. See Breach Notification section below for more information on breach of information and risk assessment.

RBE's Duties:

We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will post a notice of the revision in the waiting room and notify you at your next appointment.

Breach Notification:

- If we become aware of or suspect a breach, as defined in Section 1 of the breach notification Overview (see Attachment A), we will conduct a Risk Assessment, as outlined in Section 2.A of the Overview. We will keep a written record of that Risk Assessment.
- Unless we determine that there is a low probability of that PHI has been compromised, we will give notice of the breach as described in Sections 2.B and 2.C of the breach notification Overview.
- The risk assessment can be done by a business associate if it was involved in the breach. While the business associate will conduct a risk assessment of a breach of PHI in its control, we will provide any required notice to patients and Health and Human Services.
- After any breach, particularly one that requires notice, we will reassess its privacy and security practices to determine what changes should be made to prevent the reoccurrence of such breaches.

V. Complaints

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact our office manager, Michelle Sobresky at Ext. 118, or by fax at 610-323-6058 or by mail at this address. You may also send a written complaint to the Secretary of the U.S. Department of Health and

situations rarely occur, but if they do, we will make every effort to fully discuss it with you before taking action.

- **Worker's Compensation:** If you file a worker's compensation claim, we will be required to file periodic reports with your employer which shall include, where pertinent, history, diagnosis, treatment, and prognosis.
- **When the use and disclosure without your consent or authorization is allowed under other sections of Section 164.512 of the Privacy Rule and the state's confidentiality law:** This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as Health and Human Services or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

IV. Patient's Rights and RBE's Duties Patient's Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing us. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy* – You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). On your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy* – You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.
- *Right to Request Records in an Electronic Format*- You have a right to receive a copy of your PHI in an electronic format if it is readily producible and to the

authorization from you before releasing this information. You must sign an authorization for releases that are not mentioned in this Privacy Notice in Section III below. You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reason to suspect, on the basis of our professional judgment, that a child is or has been abused, we are required to report our suspicions to the authority or government agency vested to conduct child abuse investigations. We are required to make such reports even if we do not see the child in our professional capacity. We are mandated to report suspected child abuse if anyone aged 14 or older tells us that he or she committed child abuse, even if the victim is no longer in danger. We are also mandated to report suspected child abuse if anyone tells us that he or she knows of any child who is currently being abused.
- **Certain adolescent sexual relationships:** We also must report it when adolescents less than 13 years of age engage in sexual activity or when adolescents less than 16 years of age engage in consensual sexual activity with someone more than four years older.
- **Adult and Domestic Abuse:** If we have reasonable cause to believe that an older adult is in need of protective services (regarding abuse, neglect, exploitation or abandonment), we may report such to the local agency which provides protective services.
- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made about the professional services we provided you or the records thereof, such information is privileged under state law, and we will not release the information without your written consent, or a court order. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.
- **Serious Threat to Health or Safety:** If you express a serious threat, or intent to kill or seriously injure yourself or an identified or readily identifiable person or group of people, and we determine that you are likely to carry out the threat, we must take reasonable measures to prevent harm. Reasonable measures may include directly advising any potential victim of the threat or intent, contacting the police, contacting your family member(s), or seeking hospitalization. These

HIPAA Privacy Notice

Notice of Ramesh B. Eluri, MD.,PC. Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may *use* or *disclose* your *protected health information* (*PHI*), for *treatment, payment, and health care operations* purposes with your *consent*. To help clarify these terms, here are some definitions:

- "*PHI*" refers to information in your health record that could identify you.
- *"Treatment, Payment and Health Care Operations"*
  - *Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage. This may include an electronic clearing house used to bill electronically and a technology company to help us manage our computer systems.
  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination. This may include an answering service, shredding company, and financial services.
- "*Use*" applies only to activities within Ramesh B. Eluri, MD., PC. (RBE) such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- "*Disclosure*" applies to activities outside of my RBE, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "*authorization*" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment and health care operations, we will obtain an