Welcome to Dean Clinic Department of Psychiatry!

The Department of Psychiatry provides the benefits of a system of care within a multi-specialty clinic. In the next two pages, we will outline how we provide services at Dean Clinic Department of Psychiatry. The pages following this, we inform you about our cancellation policy, patient rights and ask for your consent for treatment. Please review this important information. If you have questions, please talk to your provider.

The research is very clear: Patients do get better when they actively participate in their mental health care and keep their scheduled appointments. With that in mind, please let your provider know if there is anything that would prevent you from attending follow up appointments or fully participating in your treatment plan at this or at any time.

Finally, I want to thank you for choosing Dean Clinic Department of Psychiatry as your mental health provider. I hope your visit with us today is informative and that your future visits help you reach your treatment goals.

Thank you,

Bhawani Ballamudi, MD
Division Chief, Department of Psychiatry
**Dean Clinic Department of Psychiatry**

**Your initial appointment:** At the first appointment, your Department of Psychiatry provider will ask you questions and review your history to get a good understanding of your concerns. This assessment will help your provider counsel you on how we can best to address your needs, and help you develop goals for your treatment and a plan to reach them.

**Treatment Services:** Your treatment plan may include the prescription of medicine, psychotherapy (talk therapy) or further assessment. Psychotherapy may involve one or more of the following: individual, couples, family or group psychotherapy. Your provider will help you decide upon when and how frequently you should be seen for you to obtain benefit from treatment. Treatment will begin only after you give your consent to move forward.

**Your treatment team:** Your “treatment team” includes any health care provider who is involved in providing your medical or mental health care, both at Dean Clinic and elsewhere. Team members from the Department of Psychiatry may include a psychiatrist along with a nurse or medical assistant, a psychologist, or masters prepared psychotherapist.

**Emergency Care:** While you are an active patient of the Department of Psychiatry, emergency care for a non-life threatening concern is available to you should you need it outside of regularly scheduled follow-up appointments. *For life threatening emergencies, call 911 or go to the nearest emergency room.*

- During business hours: Call and ask for your current mental health provider. You will be connected directly to your provider or to one of your other team members (e.g. a nurse, if you’re seeing a doctor). If necessary, you will be connected to one of our on-call providers.

- After business hours your call will be answered by the Dean Call Center. The Dean Call Center will connect you to the Department of Psychiatry after hours call clinician, who is a mental health professional with the Department of Psychiatry.

**Your Health Care Information:** Care notes and information will be available to your treatment team. Team members can review these notes only when there is a treatment reason to do so, in compliance with the Health Information Portability and Accountability Act of 1996 (HIPAA). For example, your family provider will be able to look at your record to determine why you are receiving psychotherapy or medications to avoid complications with other treatment and to support your treatment here.

Like all your medical records, anyone who reviews your record must have a business reason* for doing so; *and must only review information necessary to complete the task at hand,* nothing more, nothing less.

*Appropriate business reasons to access your medical record include treatment (as mentioned above), payment (the information necessary for billing and payment of your claims) or operations (to conduct certain administrative, financial, legal, and quality improvement activities of a covered entity that are necessary to run its business and to support the core functions of treatment and payment).*
Your psychiatry provider may verbally communicate with members of your treatment team when there is a treatment reason to do so. For example, your psychiatry and your family provider may speak over the phone to determine the best course of action for medications to improve your care, to order tests, or even to arrange hospitalization.

Any authorization to release copies or summaries of your Dean Clinic health care information for any purpose not covered by HIPAA (treatment, payment, or operations) will still require your signature first.

Dean Clinic monitors access to patient records. Employees who access records without a business reason for reviewing them will be disciplined according to company policy.

**Service Fees:** Fee information is available upon request. Contact Patient Account Services at 608-250-1593. Common service codes are: 90791 90792, 99213, 99214, 99215, 90832, 90833, 90834, 90836, 90837, 90338, 90847, 90853, 96150, 96152, 96154, 96153

**Insurance Benefit Limitations:** Please note that benefits for mental health or alcohol and drug treatment (AODA) may be limited by your health plan, require prior authorization or there may be a co-pay or coinsurance to satisfy.

It is your responsibility to check the status of your benefits with your insurance carrier, and to obtain any required authorization if necessary.

If you have reached your benefit maximum, you may: 1) continue to receive services at your own expense, 2) contact your County agency for possible financial assistance for continued services, or 3) wait until benefits renew to receive covered services. You may discuss these concerns with your provider should they arise.

**Fees Not Covered by Insurance:** There are some services that are not covered by some insurance carriers. These typically include evaluations ordered by the court, treatment summary letters, and reports to third parties. If you request such services, you will be billed per our current fees.

**Discharge from Care:** While rare, it may be necessary to inform patients that their provider or the Department of Psychiatry can no longer offer services. This can happen when patients miss appointments, have difficulty following prudent treatment recommendations, or for behaviors that put patients or clinic staff at risk of harm or abuse.

*If you have further questions about any of the above, please discuss these with your provider.*
When you attend and arrive on time for your scheduled appointments, you will receive the greatest benefit from our services. Yet, there may be times when you need to cancel and reschedule your appointment. If you must cancel, we need at least a 24 hour notice to make sure we can reschedule another patient in your appointment time. Please read the following information carefully. If you have questions, please ask your provider to answer them.

**Canceling an Appointment**

- Contact us with at least 24 hours notice (see Clinic numbers below)

- MONDAY APPOINTMENTS: Contact us on the previous Friday before noon.

**Missing an Appointment** (no show, late cancel, or late arrival with insufficient time to be served)

- If you miss an appointment, any future appointments with your Department of Psychiatry provider may be canceled; and, your ability to reschedule with your provider may be limited.

- You will be given notice if you miss, cancel late or arrive late for two appointments with your provider or members of your treatment team.

- Your provider or treatment team may decide to discontinue further care if you miss, cancel or arrive late three times. You may be referred to follow up with other Dean Clinic providers. You will be notified of this decision in writing.

- You may not be able to obtain further care from any Dean Clinic Department of Psychiatry provider if your care is discontinued for a second time. You will be notified of this decision in writing.

- If you have good reasons for missing or coming late, please discuss them with your provider as soon as possible.

**Appointment Reminder System**

- The Department may institute an appointment reminder system. However, you are responsible for keeping your previously scheduled appointments whether reminded or not.

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If you need to schedule or cancel an appointment with your Dean Clinic Psychiatry Provider, please contact us at the appropriate number below

**Department of Psychiatry Appointment Desks**

Dean Clinic-Fish Hatchery: 252-8226
Dean Clinic-East: 260-6006
Dean Clinic-Sun Prairie: 825-3777
Dean Clinic-West: 824-4777
Dean Clinic-Janesville East: 371-8625
I have been provided information regarding psychiatric treatment, and understand that I have the following rights as an outpatient of the Dean Clinic Department of Psychiatry:

1. Receive prompt, adequate, and appropriate treatment, rehabilitation and/or educational services.
2. Be informed about and participate in the planning of your treatment and care.
3. Give informed consent regarding the following: benefits of the proposed treatment services; the way the treatment and services are to be administered and provided; the expected treatment side effects or risks of side effects that are a reasonable possibility, including the side effects from medications; alternative treatment modes and services; the probable consequences of not receiving proposed treatment and services.
4. Refuse treatment or medication, unless the court has required it or there would be imminent danger to yourself or others without this treatment.
5. Refuse any medication which may be unnecessary or excessive.
7. Have information about your treatment kept confidential, according to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Any authorization to release copies or summaries of your Dean Clinic protected information will require an authorization signed by the patient or legal representative unless the request is related to Treatment, Payment or Operations as defined by HIPAA regulations.*
8. Request to see records pertaining to your physical health and medications during the course of your treatment.
9. Prior to discharge, your access to the entire record may be limited if there are clinical reasons to do so. You have a right to know the reason(s) and/or to challenge them through a grievance process.
10. Request to see your entire treatment record after you are no longer in treatment.
11. Challenge the accuracy of any part of your record through a grievance process, and/or submit your own written version to be included in your record.
12. And, be provided, upon request, a copy of Wisc. Stat. Sec. 51.30, 51.61, and/or HFS 94 of the Wisc. Administrative Code. Copies of the pamphlet, “Client Rights and the Grievance Procedure for Community Services” are available at the Department of Psychiatry reception area.

*Exceptions to this include court orders or situations of potential danger to self and others, including child protection.

I understand that I have the ability to discuss my rights, or to request additional information about my rights, at any time in the course of my treatment. I have participated in formulating my treatment plan with my provider, and I have had information regarding my treatment (as outlined above in #3) explained to me so that I understand. I have also been advised of the cost of treatment. I agree to participate in this treatment plan. I understand that I have the right to withdraw this informed consent, in writing, at any time. The informed consent is not valid for longer than twelve (12) months from the date of this document.

____________________________________________    ______________
Signature of Patient        Date

____________________________________________    ______________
Signature of Person Authorized by Patient      Date

(Parent, guardian, legal custodian of minor or patient adjudged incompetent)
Dean Clinic uses an automated appointment reminder system to remind patients of their upcoming appointments. As a courtesy, we will contact you with a reminder call within 48 hours of your next appointment (or more if your appointment follows a weekend or holiday). We will contact you, leave a message with your answering machine, or leave a message with whoever answers at your home telephone number. If we contact you, leave a message on your answering machine, or speak to someone other than yourself, we will simply say you have an appointment with Dean Clinic, specifying only which Dean location, the date, the time of the appointment, and a call back number if you have questions.

1. _______ **I want to receive reminder calls** from the Department of Psychiatry to remind me of upcoming appointments, including leaving a message with my answering machine or with whoever answers at this number. I understand that this consent will remain in effect while I’m in treatment at any of the Department of Psychiatry locations. I can revoke this consent at any time, but I must do so in writing.

2. _______ **I do not want to receive reminder calls. I understand that by requesting this I will not receive reminder calls for appointments with ANY Provider in the Dean Clinic Department of Psychiatry.** I am aware that this understanding will remain in effect while I’m in treatment at any of the Department of Psychiatry locations. I can give my consent to receive reminder calls at any time, but I must do so in writing, using a separate Reminder Call Consent form supplied by the Department of Psychiatry.

Patient Name (print): ____________________________________________

___________________________________ Date: __________

Signature Patient (14 and above)

___________________________________ Date: __________

Signature of Parent or Guardian (for patients under 18 years of age)
DEPARTMENT OF PSYCHIATRY INITIAL TREATMENT PLAN: (check all that apply)

____ Individual Therapy
____ Group Therapy assessment/referral
____ Medication evaluation w/ Department psychiatrist
____ Refer for Psychological Testing
____ Family Therapy
____ Contact provider for AODA assessment/treatment
____ Follow up with PCP regarding medications
____ Other ____________________

I ___________________________________________________________________________ have participated in developing my treatment plan as ________________
(Patient name)

outlined above, and agree with the proposed method of treatment of services.

Patient Signature: ___________________________________________________________________________ Date: ________________

Parent/Guardian Name: ______________________________________________________________________

Parent/Guardian Signature: ____________________________________________________________________

Relationship to patient: ______________________________________________________________________

This document has been sent for scanning into patient’s Mental Health Record.