Mind Over Matter Psychiatry

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P:(646)-397-6063

Office Policies and Procedures

APPOINTMENTS AND CANCELLATIONS

Initial Consultation: 60–90-minute session

- Our goal for this session will be to gather information, assess personal goals, obtain lab work or other medically necessary records, and discuss future treatment courses with you.

Medication Management: 25–30-minute session

- Visits are required, by state law, every 30 days for patients that have been prescribed controlled substances.
- To maintain an effective treatment relationship, patients receiving medication must be seen at least once every three months. We ask that the patient (or guardian's) schedule these appointments in advance.

Follow-up Therapy: 40–45-minute session

Unfortunately, we will not be able to extend any sessions due to a late arrival.

CANCELLATIONS

At least 24 hours' notice is required for any cancellations or changes in appointment time. In the event this notice is not given, the patient's credit card on file will be charged for the full visit amount. This is necessary because a time commitment is made to you and is held exclusively for you. If you should arrive late for a session, you may lose the session time that you missed.

TELEPHONE ACCESSIBILITY

Dr. Singer can be reached by telephone at 646.397.6063 as well as email at drs@dnppsych.org. Dr. Singer is often not immediately available; however, will respond to all communications within 1 business day. If a true emergency arises, please call 911 or go to any local emergency room.

If you or anyone you know are in a crisis or may be in danger, please use the following resources to get immediate help. Please see our up-to-date list of national help lines below:

NUMBER	ORGANIZATION
911	Emergency
+1 (800) 273-8255	National Suicide Prevention Lifeline
+1 (800) 656-4673	National Sexual Assault Hotline
+1 (800) 784-2433	National Hopeline Network - links callers to nearest crisis center
+1 (800) 366-8288	S.A.F.E. Alternatives for Stopping Self-Harm
+1 (800) 622-2255	Alcoholism & Drug Dependency Hope Line
+1 (800) 931-2237	National Eating Disorder Association
+1 (866) 488-7386	Trevor Crisis Hotline - confidential suicide hotline for LGBTQ youth
+1 (877) 565-8860	Trans Lifeline - crisis hotline run by trans folks for trans and questioning callers
+1 (800) 799-7233	National Domestic Violence Hotline
+1 (800) 996-6228	Family Violence Helpline
+1 (800) 230-7526	Planned Parenthood Hotline
+1 (800) 222-1222	American Association of Poison Control Centers
741741	Crisis Text Line

ELECTRONIC COMMUNICATION

We cannot guarantee the confidentiality of any form of communication through electronic means, including email and text messages. If you prefer to communicate via email or text messaging for issues regarding scheduling or cancellations, our practice will accommodate these methods of communication. We request that you do not use these methods of communication to discuss therapeutic content and/or request assistance for emergencies. If a true emergency arises, please call 911 or go to any local emergency room.

BILLING

To provide uninterrupted, organized care, our practice requires a credit card to be stored in your file. As explained previously, this policy is necessary because a time commitment is made to you and is held exclusively for you. Your credit card on file will be charged at the time of service. Your receipt for payment can be sent to you following your appointment upon request. Otherwise, billing statements for treatment will be generated and sent to you at end of each calendar month.

These billing statements contain the necessary information for requesting potential insurance reimbursement. However, Mind Over Matter Psychiatry cannot guarantee reimbursement by your insurance. At least 24 hours' notice is required for any cancellations or changes in appointment time. In the event this notice is not given, the patient's credit card on file will be charged the full visit amount. By signing this form, you are acknowledging and approving Mind Over Matter Psychiatry to store your credit card and process payments for services rendered.

Mind Over Matter Psychiatry does not currently accept insurance directly. However, reimbursement from your insurance can be pursued personally by discussing your policy and out-of-network benefits with your insurance carrier.

OUT OF POCKET FEES

New York

- Initial session: $525 (60min)
- Individual session: $300 (30min)
- Individual session: $350 (45min)
- Genetic/Pharmacogenomic Session: $550
- (Sliding Scale available upon request)

South Carolina

- Initial session:
- Individual session:
- Individual session:
- Genetic/Pharmacogenomic session:
- (Sliding Scale available upon request)

NO SURPRISE ACT & GOOD FAITH ESTIMATE

You are entitled to receive a "Good Faith Estimate" explaining how much your medical care will cost.

- Under this law, health care providers need to provide patients who don't have insurance, or who are not using insurance, an estimate of the bill for medical items and services.
- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services that are reasonably expected at the time of scheduling. This includes related costs like medical tests, equipment, and hospital testing.
- For patients who don't have insurance or who are not using insurance, Mind Over Matter Psychiatry will provide a Good Faith Estimate of scheduled services in writing before the medical service or item if requested.
- You can also ask Mind Over Matter Psychiatry, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

- Make sure to save a copy or picture of your Good Faith Estimate.
- For questions or more information about your right to a Good Faith Estimate, visit https://www.cms.gov/nosurprises/.
- This notice is not intended to be a full summary of the No Surprises Act. It is intended only to be a general information summary of technical legal standards. Readers should refer to the applicable statutes, regulations and other interpretive materials and complete and current information.

If you choose to go out-of-network for specialized care in a non-emergency situation, you waive your right to balance billing protections listed in the No Surprises Act. By signing below you are acknowledging your understanding of these rights and conditions. For questions regarding the No Surprises Act, please feel free to visit our practice website at www.mindovermatterpsychiatry.org.

TERMINATION

It is important to have a written termination process to achieve some closure for all parties involved. I may terminate treatment after appropriate discussion with you and a termination process if I determine that the psychotherapy is not being effectively used. I will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If therapy is terminated for any reason or you request another therapist, I will provide you with a list of qualified psychotherapists to treat you. You may also choose someone on your own or from another referral source. Should you fail to arrive at your appointments for three consecutive weeks, unless other arrangements have been made in advance, for legal and ethical reasons, I must consider the professional relationship discontinued.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Signature

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NOTICE OF PRIVACY PRACTICES

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

I. DR. SINGER'S PLEDGE REGARDING HEALTH INFORMATION: I understand that health information about you and your health care is personal. I am committed to protecting health information about you. A record is created of the care and services you receive from me. This record is necessary to provide you with quality care and to comply with certain legal requirements. This notice applies to all the records of your care generated by this mental health care practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you and describe certain obligations I have regarding the use and disclosure of your health information.

   I am required by law to:

   • Make sure that protected health information ("PHI") that identifies you is kept private.

   • Give you this notice of my legal duties and privacy practices with respect to health information.
   • Follow the terms of the notice that is currently in effect.

   • I can change the terms of this Notice, and such changes will apply to all information I have about you.

   An up-to-date notice will be available upon request and posted to our practice website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain further and try to give some examples. Not every use or disclosure in a category will be listed. However, all the ways I am permitted to use and disclose information will fall within one of the categories. For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client's personal health information without the patient's written authorization, to carry out the health care provider's own treatment, payment, or health care operations. I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. Disclosures for treatment purposes are not limited to the minimum necessary standard. Therapists and other health care providers need access to the full record and/or full and complete information to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another. Lawsuits

and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Psychotherapy Notes. I keep "psychotherapy notes" as that term is defined in 45 CFR § 164.501, and any use or disclosure of such notes requires your Authorization unless the use or disclosure is: a. For my use in treating you. b. For my use in training or supervising mental health practitioners to help them improve their skills in group, joint, family, or individual counseling or therapy. c. For my use in defending myself in legal proceedings instituted by you. d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA. e. Required by law and the use or disclosure is limited to the requirements of such law. f. Required by law for certain health oversight activities pertaining to the originator of the psychotherapy notes. g. Required by a coroner who is performing duties authorized by law. h. Required to help avert a serious threat to the health and safety of others. 2. Marketing Purposes. As a psychotherapist, I will not use or disclose your PHI for marketing purposes. 3. Sale of PHI. As a psychotherapist, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION. Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons: 1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law. 2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety. 3. For health oversight activities, including audits and investigations. 4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so. 5. For law enforcement purposes, including reporting crimes occurring on my premises. 6. To coroners or medical examiners, when such individuals are performing duties authorized by law. 7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions. 9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI to comply with workers' compensation laws. 10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT. 1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI: 1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it will affect your health care. 2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full. 3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests. 4. The Right to See and Get Copies of Your PHI. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost-based fee for doing so. 5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request. 6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request. 7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it. EFFECTIVE DATE OF THIS NOTICE This notice went into effect on June 24, 2022, Acknowledgement of Receipt of Privacy Notice Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. By signing below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Patient Signature

INFORMED CONSENT

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself. The session content and all relevant materials to the client's treatment will be held confidential unless the client requests in writing to have all or portions of such content released to a specifically named person/persons. Limitations of such client held privilege of confidentiality exist and are itemized below: 1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a way there is a substantial risk of incurring serious bodily harm. 2. If a client threatens grave bodily harm or death to another person. 3. If the therapist has a reasonable suspicion that a client or other named victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years. 4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses. 5. Suspected neglect of the parties named in items #3 and # 4. 6. If a court of law issues a legitimate subpoena for information stated on the subpoena. 7. If a client is in therapy or being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney. Occasionally I may need to consult with other professionals in their areas of expertise to provide the best treatment for you. Information about you may be shared in this context without using your name. I provide psychotherapy and contemporary psychoanalysis for adult individuals and couples. I am trained in a wide variety of therapeutic techniques and use an integrative approach, drawing from my training to employ the tools that I believe will best serve the client.

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Patient Signature

CONSENT FOR TELEHEALTH CONSULTATION

Dr. Singer uses two-way videoconferencing to enable you to participate in treatment sessions from a location convenient to you. This videoconferencing is referred to as Telepsychiatry. Sessions conducted via videoconference are similar to face-to-face treatment sessions, allowing you to communicate in real-time while also seeing your provider on screen. Although there are many benefits to telepsychiatry, there are also some risks and limitations. In an effort to protect our patients from potential risks our practice has taken the necessary steps to minimize risk and keep our patients safe.

Video sessions will be encrypted and adhere to HIPAA data privacy requirements. We will not record any of our sessions. However, the patient understands that there are still potential risks to this technology, including interruptions, unauthorized access, and technical difficulties.

At the beginning of each video consultation, (I) the patient will provide my physical location and understand that local emergency resources will be contacted and sent to my location in an emergency.

I understand that my provider will engage in treatment with me via telepsychiatry consultation. My provider explained to me how the video conferencing technology will be used. I understand that a telepsychiatry consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand that the laws that protect privacy and the confidentiality of medical information also applies to telehealth; those appropriate measures will be taken to secure transmitted information and maximize privacy and confidentiality. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I have had a direct conversation with my provider, during which I had the opportunity to ask questions regarding this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed. I hereby give my informed consent for the use of telepsychiatry in my medical care.

BY SIGNING BELOW, I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS ENTIRE DOCUMENT

Patient Signature

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Date

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