HENRY WOODWORTH, M.D., P.C.

reconstructive psychiatry

for a sustainable consciousness

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CLIENT SERVICES AGREEMENT

Welcome to our practice! A good relationship requires an understanding of what each party expects of the other. Below, you will find a description of what you can expect from me and what I expect from you. If you have any questions, feel free to ask. After you have read this agreement, please sign at the end to acknowledge your receipt and understanding. We look forward to working with you.

Appointments and Fee Schedule

Your first appointment will be an initial evaluation where we will discuss your history and your current concerns. This also is an opportunity for you and me to decide whether I am the psychiatrist for you. Your first appointment will usually last less than 90 minutes. Occasionally, we will not have finished our evaluation in that time and you will be asked to schedule an additional appointment.

After your initial evaluation, we will recommend the treatment that would be most helpful for you. This may include medication, therapy, or work with other professionals to whom we will refer you. Frequency and duration of future appointments will depend on the evaluation and selected treatment.

Initial evaluation	75-85 minutes	$795
Full session	55 minutes	$430
Half session	25 minutes	$220

Additional fees apply for related services, such as letter writing, consultations with other professionals, extended telephone calls, etc.

Payment

We are a fee-for-service practice. Payment is expected before or at the time of the appointment. We take cash, personal check, VISA, Mastercard, and Discover. There will be a $35 fee for returned checks. In addition, we require a credit card on file, which may be charged in case of missed appointments or additional services, such as letter writing or extended phone calls.

Prepayment

We offer discounts for prepayment. The prepaid rate for full sessions is $300, a 30% discount. The prepaid rate for half sessions is $165, a 25% discount. You may ask us to charge the credit card on file,

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give different credit card information to us on the phone, send a check, use the PayPal button on our website, or pay for your next appointment in the office when you schedule it. Prepayment must be received at least seven days before your appointment.

We require prepayment for all initial evaluations.

Cancellation and Missed Appointments

We understand that schedules change. If you need to cancel or reschedule an appointment, please do so at least 48 business hours before your appointment. You may call our office and leave a message or you may send an email. If you cancel with less than 48 business hours notice or if you fail to appear for your appointment, you will be charged the full amount of the session. Please note that insurance providers often do not reimburse for missed appointments.

If you miss an appointment without giving 48 business hours notice, we will require you to prepay for future appointments at the full rate.

Late Arrivals

A block of time has been reserved for your appointment. If you arrive late, your appointment will end at the scheduled time, and you will be charged for the full appointment. This allows us to see each patient as scheduled. In addition, if your late arrival results in an inability to complete your review, you may be asked to schedule an additional appointment.

Insurance

Dr. Woodworth is considered an out-of-network provider for all insurance. This means that you pay the full amount for the appointment before or at the time of service. We will give you a receipt, which you may send to your insurance company. Please check with your insurance company about the specific benefits you may receive for out-of-network providers.

Medication

Medication may become part of your treatment. For your safety, we ask that patients come in at least quarterly for medication review. This can be done during a half session if you have no medical complications or other concerns to discuss. We may also require laboratory tests for certain medications, which will be discussed with you during your appointment.

Medication refills must be requested at least seven days in advance. For most prescriptions, you may call us to request your refill or you may ask your pharmacy to contact our office. If you contact us, please be prepared with your name, date of birth, contact phone number, medication name, dosage, and

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frequency. We will consult your chart, as well, but this information expedites the process. We reserve the right to require an appointment before prescribing refills.

Some patients may be prescribed controlled substances. By law, these prescriptions cannot be called or faxed into your pharmacy. You must pick up a physical prescription from our office and take it to your pharmacy. Please make sure you leave enough time to do so during our office hours so that you do not experience an interruption in your medication.

Confidentiality

Our work together will be held in confidence. For your protection, we must have written permission to release your records to anyone, including another physician, or to discuss your case with another person. We will provide a form if you need to make such a request.

State law requires us to disclose otherwise confidential information in a few circumstances, including, but not limited to, the following:

- if there is threat of harm to yourself or others
- if there is indication of abuse of a child, elderly person, or disabled person
- in rare cases, when ordered to do so by a court

Termination

The relationship between patient and physician is an important one, but sometimes the fit is not comfortable. If you wish to discontinue treatment with us, please notify us in writing. We will be happy to provide you with referrals to other physicians or therapists.

Communication and Emergencies

You may contact us via telephone at 248-348-0333 or you may email us at drwoodworth@gmail.com. We do our best to return messages in a timely manner. If you have a time-sensitive question or request, please call rather than email us.

Unfortunately, we may not always be immediately available to help in a crisis. If you have an emergency, please call 911. If you have a psychiatric emergency, we suggest you contact Havenwyck Hospital Intake Department at 248-373-9200 for assistance.

Additional Information

This information is subject to change without notice. Any changes can be found on our website, in additional to other relevant forms and information. Please visit us at www.drwoodworth.com.

HENRY WOODWORTH, M.D., P.C. r e c o n s t r u c t i v e p s y c h i a t r y
toward a s u s t a i n able c o n s c i o u s n e s s
drwoodworth@gmail.com

CLIENT SERVICES AGREEMENT
ACKNOWLEDGEMENT OF RECEIPT AND UNDERSTANDING

I acknowledge that I have received, read, and understood the Client Services Agreement. I understand that the contents of this agreement are subject to change without notice and that changes can be found at www.drwoodworth.com.

Signature of Client or Responsible Party_____ Date_____

Signature of Non-paying Client_____Date_____
(i.e. client who is over 18 years old but who is not financially responsible for treatment)

HENRY WOODWORTH, M.D., P.C. r e c o n s t r u c t i v e p s y c h i a t r y

toward a s u s t a i n able c o n s c i o u s n e s s

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CREDIT CARD AUTHORIZATION

Client Name_____

Name (as it appears on credit card) _____

Billing Address_____

City_____ State_____ Zip Code_____

VISA_____ Mastercard_____

Credit Card Number_____ Exp date_____ 3 digit security code_____

I authorize Henry Woodworth, MD, PC, to bill the above credit card for professional services for the above-named client, including, but not limited to, office appointments, Skype appointments, extended telephone consultations, and requested written documents. I also authorize Henry Woodworth, MD, PC, to bill the above credit card for returned checks and associated fees.

I further authorize Henry Woodworth, MD, PC, to bill the above credit card for the full charge of my appointment if I do not give at least 48 business hours notice of cancellation or if I do not appear for my appointment.

Signature of card holder_____ Date_____

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ELECTRONIC COMMUNICATION CONSENT FORM

While electronic communication, such as email and Skype, is convenient, it is subject to certain risks. We would like you to be aware of these risks if you choose to communicate electronically with our office. Risks include, but are not limited to, the following:

1. Email may be circulated, forwarded, and store in paper and electronic files.
2. Email may be misaddressed or accidentally received by unintended recipients.
3. Backup copies of email may exist even after the sender or the recipient has deleted his or her copy.
4. Email may be intercepted, altered, forwarded, or used without authorization or detection.
5. Email may be used as evidence in court.
6. Email may not be secure and, therefore, confidentiality cannot be guaranteed.
7. Employers have a right to inspect email transmitted through their systems.

Henry Woodworth, MD, PC, will take all reasonable measures to ensure the security and confidentiality of electronic communications. However, because of the risks of electronic communication, Henry Woodworth, MD, PC, will not be liable for improper disclosure of information that is not caused by our intentional misconduct.

Email is not appropriate for communication of urgent or emergency situations.

I understand the risks associated with electronic communication as outlined above. I have read and understood this consent form and agree to the conditions herein. I understand that I may ask any future questions of Henry Woodworth, MD, PC, regarding this document.

Client Name_____

Signature of client_____ Date_____
(or parent or legal guardian if client is a minor)

HENRY WOODWORTH, M.D., P.C. r e c o n s t r u c t i v e p s y c h i a t r y
toward a s u s t a i n able c o n s c i o u s n e s s
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CONTACT CONSENT FORM

We want to make sure that your medical information remains secure and that we are in compliance with HIPPA privacy requirements. Please let us know below with whom we may discuss your treatment, if any. This may be a parent, a significant other to whom you are not legally married, or anyone else who you feel should be party to your information.

You are welcome to update this form at any time. Simply print a blank copy from our website, complete it, and bring it with you to your next appointment. Alternatively, you may request a blank copy when you come into the office and complete it while you are waiting.

Client Name_____

I authorize Henry Woodworth, MD, PC, to share my medical information with the following:

Name	Telephone number	Relationship
Name	Telephone number	Relationship
Name	Telephone number	Relationship

Signature of client_____ Date_____
(or parent or legal guardian if client is a minor)