

PRINTED NAME: \_\_\_\_\_

**PRIVACY PRACTICES**

I have heard the overview of the privacy practices for Solstice Psychiatric Consulting, P.C. The exceptions to maintaining confidentiality have been explained. I have received, reviewed, or read a full copy (available on our website) of the notice of Privacy Practices-Revised 10/16/2006. If I have any questions at any time, I will bring them to the attention of my clinician at Solstice Psychiatric Consulting.

Initials: \_\_\_\_\_

**EMAIL POLICIES**

I understand that e-mail is not a totally secure form of communication and allow for the following address to be used for simple communications including appointment reminders: \_\_\_\_\_. I also agree that sensitive medical and psychiatric information may be sent to me via password-protected, encrypted email. I may initiate an encrypted email message through the contact form on the website, [www.solsticenyc.com](http://www.solsticenyc.com). FURTHERMORE, I UNDERSTAND THAT E-MAIL IS NOT OPTIMAL FOR URGENT COMMUNICATIONS (THOSE REQUIRING RESPONSE WITHIN 24-48 HOURS) AND FOR SUCH URGENT COMMUNICATIONS I SHALL CALL THE 24 hr ANSWERING SERVICE AT 877-657-8423.

Initials: \_\_\_\_\_

**BILLING PRACTICES**

I understand that fees incurred for professional services at Solstice Psychiatric Consulting, P.C., are my sole responsibility and payable at the time of service. I understand that if insurance claims are to be filed, Solstice Psychiatric Consulting, P.C. will provide necessary information about services rendered and fees collected, however the filing of these claims are my responsibility. In addition, I understand that missed or cancelled appointments with notice less than 1 business day will incur a fee of no less than ½ of the normal fee. Missed appointments outside of normal business hours (9a-5p, M-F), may be charged at the full fee.

Initials: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_