Rittenhouse

PSYCHIATRIC ASSOCIATES

1528 Walnut Street #1414 & 1415, Philadelphia,
PA, 19102 30 S. Valley Rd. #101, Paoli, PA 19301

Patient Information

Legal First Name: _____ Middle Initial: _____ Last Name: _____

Preferred Name and Pronouns: _____ Sex & Gender: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

E-Mail Address: _____

Please check how we may contact you: ☐ **Cell** ☐ **E-Mail** ☐ **Home** ☐ **Work**

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Pharmacy (Name & Address): _____ Phone: _____

Insurance: _____ ID Number: _____

Prescription Benefits Card Company and ID # (if separate from insurance card [Express Scripts, Future Scripts, CVS Caremark, Optum Rx etc].) _____

How Did You Hear About Us (if a provider, please include their name)? _____

Do you have Medicare? _____ (*Our providers have either have opted out of Medicare or cannot see patients who bill Medicare at this office. This means that if you have Medicare and submit a bill for reimbursement to them, you are committing medical fraud and are subject to penalties, fines and other legal repercussions).*

I have read the Office Policies handout and understand that I am responsible for full payment at the time of service, that my provider does not participate with any insurance companies, that I cannot submit claims to Medicare and that I will be charged for phone appointments, any missed appointments and appointments cancelled with less than 48 business hours notice Monday to Friday 9AM-5PM (for example, if my appointment is on a Tuesday at noon, I must cancel by the previous Friday at noon or I will be charged the full appointment fee). I give my provider permission to charge my credit card on file, for any charges that are due, at his/her discretion.

Patient Signature:

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Personal Medical and Psychosocial Information

In one sentence, what brought you to make your appointment?

Psychiatric Conditions *(include conditions DIAGNOSED by a professional. Examples: ADHD, depression, generalized anxiety, bipolar disorder, eating disorders, borderline personality disorder, etc.)*:

Medical Conditions *(Include ALL conditions you have **ever** been diagnosed with (ex: reflux, ulcerative colitis, asthma, diabetes, high blood pressure, IBS, cancer, high cholesterol, stroke, heart attack, seizures, migraines, sleep apnea or write **NONE**):*

Surgeries *(Include year performed):*

Significant Injuries (*Include year. Ex: major car accidents, gunshot wounds, head trauma, broken bones, concussions, or **NONE***):

Medication Allergies or Sensitivities *(Include reaction when exposed. **Write NONE if none**).*

Current Medications, Dose, and Frequency *(Include ALL medications you take [not just psychiatric]). Include medications taken as needed, over the counter meds, birth control, IUDs, birth control implants, herbal supplements/vitamins) **Write NONE if none**).:*

List psychiatric medications ever taken and the max dose (meds for depression, anxiety, attention. sleep. etc).

Primary Care Provider: **Phone:** **Last Visit:**
Therapist: **Phone:**
Have you served in the military?:
Do you own or rent? Do you live with others (who?):
Sexual Orientation: **Religion:**
Race and Ethnicity:
Occupation/Profession:
Highest Level of Education: **Major**:

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FAMILY MENTAL HEALTH & SUBSTACE USE ASSESSMENT

Please check off any BIOLOGICAL family members who have had the following issues acknowledged by a mental health professional.

1) MAJOR DEPRESSIVE DISORDER (depression, including seasonal & post-partum)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

2) BIPOLAR DISORDER (aka manic depression)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

3) GENERALIZED ANXIETY DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

4) OBSESSIVE COMPULSIVE DISORDER OR HOARDING

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

5) PANIC DISORDER/ PANIC ATTACKS

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

6) POST-TRAUMATIC STRESS DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

7) PSYCHOSIS/ SCHIZOPHRENIA

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

8) SCHIZOAFFECTIVE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

9) ADHD/ADD (attention deficit)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

10) BORDERLINE PERSONALITY

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

12) EATING DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

13) DRUG USE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

14) SUICIDE ATTEMPT

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

15) COMPLETED SUICIDE

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

16) ALCOHOL USE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

17) OTHERS (autism spectrum, body dysmorphic disorder, personality disorders, any others not listed)

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BIOLOGICAL FAMILY HEALTH ASSESSMENT

Please check all boxes that apply to the specified family member.

Mother	Father	Maternal Grandparents	Paternal Grandparents	Siblings
☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes
☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes
☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death
☐ Obesity	☐ Obesity	☐ Obesity	☐ Obesity	☐ Obesity
☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid
☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid
☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome
☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects
☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia

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SUBSTANCE ABUSE ASSESSMENT

A good understanding of your current/past substance use is important for diagnosis and treatment. Please check the box next to substances EVER used in a way not directed by a medical provider and statements that apply to you.

☐ **Alcohol** - I drink alcohol [0] times per week

I usually have [0] standard drinks per occasion

(1 Standard Drink = 12 oz beer = 5 oz wine = 1.5 oz spirits)

☐ I have felt guilty about my drinking

☐ Others have annoyed me by criticizing my drinking

☐ I feel I need to cut back my drinking

☐ I have needed a drink in the morning to calm my nerves or ease a hangover

☐ I have been charged with DUI(s)

☐ I used to drink too much or too often

What age did you first drink alcohol? [ ]

	TYPE/HOW USED	AGE 1ST USE	AGE LAST USE
☐ Tobacco/Nicotine			
☐ Benzodiazepines/ Barbiturates (Xanax, Klonopin, Valium, etc)			
☐ Stimulants (Adderall, cocaine, crack, etc)			
☐ Cannabis			
☐ Steroids			
☐ Opioids (Oxy, morphine, Dilaudid, Percs, heroin, etc)			
☐ OTC meds			
☐ Synthetic Drugs (K2, PCP, etc)			
☐ Hallucinogens (acid, mushrooms, DMT, etc)			
☐ Gases/Inhalents			

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ADVERSE CHILDHOOD EVENTS ASSESSMENT

An understanding of the safety and security you experienced during your upbringing is extremely helpful to our treatment of your mental health concerns.

In the first 18 years of your life....

1) Did an adult in your household **often** swear at you, insult you, put you down, humiliate you OR act in a way that made you afraid you might be physically hurt? ☐ **YES** ☐ **NO**

2) Did an adult in your household **often** push, grab, slap, or throw something at you OR **ever** hit you so hard you had marks or were injured? ☐ **YES** ☐ **NO**

3) Did an adult or person at least 5 years older than you **ever** touch or fondle you, or have you touch their body in a sexual way OR try to or actually have oral, anal, or vaginal sex with you? ☐ **YES** ☐ **NO**

4) Did you **often** feel that no one in your family loved you or thought you were important or special OR your family didn't look out for each other, feel close to each other, or support each other? ☐ **YES** ☐ **NO**

5) Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you OR that your caretakers were too drunk or high to take care of you or take you to the doctor if you needed it? ☐ **YES** ☐ **NO**

6) Were your parents ever separated or divorced? ☐ **YES** ☐ **NO**

7) Was your mother, stepmother, father, or stepfather **often** pushed/grabbed/slapped/had objects thrown at them? OR **Sometimes** kicked, bitten, punched, or hit with something hard? OR **ever** repeatedly hit over several minutes or threatened with a gun or knife? ☐ **YES** ☐ **NO**

8) Did you live with anyone who was a problem drinker/alcoholic/used street drugs? ☐ **YES** ☐ **NO**

9) Was a household member depressed, mentally ill, or did a household member attempt suicide? ☐ **YES** ☐ **NO**

10) Did a household member go to prison? ☐ **YES** ☐ **NO**

Is there any additional information you would like your provider to be aware of prior to your evaluation?

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Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.		Never	Rarely	Sometimes	Often	Very Often
1.	How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2.	How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3.	How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4.	When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5.	How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6.	How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

Part A

7.	How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8.	How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9.	How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10.	How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11.	How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12.	How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13.	How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14.	How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15.	How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16.	When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17.	How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18.	How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

Part B

How old were you when these problems first began to occur?_____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Patient Health Questionnaire (PHQ-9)

		Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?					
a. Little interest or pleasure in doing things	a	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	b	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	c	☐	☐	☐	☐
d. Feeling tired or having little energy	d	☐	☐	☐	☐
e. Poor appetite or overeating	e	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	f	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	g	☐	☐	☐	☐
h. Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around a lot more than usual.	h	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	i	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?		Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
		☐	☐	☐	☐

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...	☐	☐
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	☐	☐
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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Office Fees and Policies

Adult Patients: 18 Years +
Nurse Practitioners: $125 Med Management / $200 45-Min family session / $275 60-Min Initial
Physicians: $225 Med Management / $375 45-Min family session / $450 60-Min Initial
Therapists: $125 45-Min Therapy / $200 Initial 60-Min Consultation
Doctoral Level Therapists: $175 45-Min Therapy / $250 Initial 60-Min Consultation
* 90 Minute Initial adult visits (all providers) are 1.5 x hourly Initial Rate

Children & Adolescents: Under 18 Years
Nurse Practitioners: $200 Med Management / $300 45-Min Therapy & Family meetings / Initial (90-min) Evaluations $550 (a followup visit is often necessary before prescribing)
Fellowship Trained Psychiatrists: $225 Med management / $375 45-Min Therapy & Family meetings / Initial Evaluations – 60-Min $450 (a followup visit is often necessary before prescribing)

Administrative Requests, Letters & Family Conferences – $100 / hour
Includes any letter or form to a third party, summaries of care, medical record requests, assistance with placement and discussion about care with individuals besides the patient (with patient permission). The patient's credit card on file is automatically used as prepayment. **Please allow 14 days for such requests.**

Appointments

Initial consultations are scheduled following a brief conversation by phone. A credit card is used to reserve your time. Evaluations are 60 or 90-Minutes in length (Child Psychiatry evaluations excluded, please discuss when scheduling) and consist of an extensive medical and psychiatric history. Laboratory studies and a brief neurological examination may be part of your workup. With permission, your provider may request collateral information from medical providers, family or significant others, to aid in case formulation and diagnosis. The initial evaluation is considered a consultation, as it is an opportunity for both the patient and provider to decide whether they are a good fit for ongoing care (individuals are responsible for the consultation fee regardless). Should both agree to work together after this consultation, follow-up appointments are either "Medication Checks" (20-minutes in length) or 45-minute therapy/ family appointments. We will collaborate to develop a treatment plan that fits your individual needs, which may include therapy, medication management or both. If you have a therapist that you would like to continue working with, we will be happy to collaborate with that individual, provided that you sign a release of information. **At a minimum, on-going patients are seen every three months.**

Payment of Fees
All fees are due at the time of service and payable by cash, check or credit card (Visa, MC, Amex, Discover). Checks should be made payable to "Rittenhouse Psychiatric Associates" or "RPA." There will be a 25 dollar fee for any returned / "bounced" checks. Accounts that are delinquent may be sent to collections. All patients are required to keep an active credit card on file (used for missed appointments, phone appointments, late cancellations, administrative work, letters & family conferences). If a patient misses two appointments, they will be required to prepay via credit card when scheduling. **There are no changes to these policies when someone other than the patient is paying for visits. Additionally, paying for visits does not change confidentiality; a patient's progress, medical record and any privileged information can still only be given with direct consent from the patient.**

Patient Signature:

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Additional Policies for Telehealth Appointments

Patients being seen for telehealth appointments (HIPAA Compliant Zoom visits for example) must review and sign an additional consent form. This form may be downloaded in the forms section of our website and is attached here.

Medical Insurance

Rittenhouse Psychiatric Associates providers are out-of-network for all medical insurance companies. If you have out-of-network mental health benefits, we will be happy to assist you by supplying bills, diagnosis and other information that is requested by your carrier for reimbursement. Patients are responsible for submitting their own claims if they choose to do so. Reimbursement is not guaranteed. Rittenhouse Psychiatric Associates and its employees do not accept Medicare. Therefore, individuals with Medicare are agreeing that they will not submit receipts for visits to Medicare (doing so is fraud).

Medication Requests and Prescription Refills

Patients may call the office and leave a message for prescription refills. Refills are called in Monday through Friday only, during normal business hours. Please allow 48 business hours for all requests. If you have not had an appointment within the last 3 months, there will be an associated 25-dollar fee (charged to your credit card on file). **If you are prescribed a controlled substance, an appointment will be required for refills**. **Lost or stolen controlled substance prescriptions will not be replaced under any circumstances, and a face-to-face appointment may be required for refills, at the provider's discretion. Additionally, we will not see patients for "emergency appointments" for lost or stolen controlled substances, or in instances where a patient "runs out" of their controlled medication, due to them taking it more frequently than it was prescribed (this is actually grounds for termination of care).**

Missed Appointments/Weather Policy/Cancellations

If you are unable to keep an appointment, please give **48 business** hours advanced notice Monday to Friday 9AM-5PM (excluding weekends and holidays), otherwise you will be charged in full for the time that was reserved for you (for example, if your appointment is on a Tuesday at noon, you must cancel by the previous Friday at noon or you will be responsible for the full appointment fee). Insurance companies do not reimburse for missed appointment charges. You may cancel your appointment by calling the office and leaving a message. If you are late for an appointment, you will be seen for the remainder of your reserved time. You will be responsible for the full session fee (this includes initial visits). We do not close due to weather, unless it is a State of Emergency. **If you miss a visit and we are unable to reach you by phone, your provider will run your credit card on file. Signing this form gives permission to do so.**

Office Coverage

If your provider is out of the office, they will leave the covering provider's information on their answering machine and in an automatic e-mail reply. For non-emergent issues, you may call the covering provider or leave a message for your provider's return. Prescription refills will be called in Monday through Friday 9AM-5PM. He/she will be able to respond to calls within 48 business hours. **Covering providers do not refill controlled substances. Patients are responsible for keeping their appointments and re-scheduling (if they cancel or miss an appointment) several weeks prior to running out of controlled substances. We are not responsible for adverse events due to failure to do so.**

Signature of Patient

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Discharge/Closing Charts

Our providers may "close" or inactivate a patient's chart for a number of reasons including *but not limited to*: a patient terminating care voluntarily (as when moving or finding a new provider), a patient violating a controlled substance agreement, a patient not following a provider's treatment recommendations, a patient's condition requiring a higher level of care than we are able to provide (as assessed by the provider), a provider assessing that they do not have the skillset required to adequately treat a patient or their condition, or a patient not following up at intervals specified by the provider.

If a patient is not seen for 3+ months, providers will mail or e-mail a letter stating that their chart will be closed unless the patient contacts their provider within a specified period of time. When a chart is "closed," we are no longer able to prescribe you medications, schedule you for appointments, or assist if you are in crisis. You are responsible for ensuring that you have office visits every 3 months or less (exact timing determined by your provider, exceptions made on a case-by-case basis) and for keeping your address/e-mail updated with our office. We are not responsible for letters not reaching their intended destination if you move/get a new e-mail and do not notify us. If a patient's chart is closed, and they would like additional information on resources in the community or finding a new provider, we will be happy to assist (call our office staff at 267-358-6155 x 1 or email Scheduling@RittenhousePA.com to receive our referral list). Additional information on finding a new provider is listed on our website: www.RittenhousePA.com/resources. Your provider will also be happy to assist you directly. If your chart is closed, and you would like to restart care, we cannot guarantee availability or that we can see you back as a patient. It will be based on provider availability and discretion, and you may be required to have an initial 60-minute visit (above fees apply).

Medical Records

Our providers generally do not release patient evaluations, progress notes or therapy notes. A summary of care will be provided to patients and/or third parties when medical records are requested. The above administrative rates apply to such requests and the card on file will be used for this service.

Contacting Your Provider

Patients have access to their provider's business phone and e-mail address. E-mail is used for scheduling and cancelling appointments, prescription requests and administrative requests only. E-mails are added to the official medical record at Rittenhouse Psychiatric Associates' discretion. We can typically return calls and e-mails within 48 business hours Monday through Friday. When patients call with questions that can be answered quickly, a fee will not be charged. If questions require a lengthy discussion (for example, any medication change), patients will be asked if they would like to schedule an office or phone appointment (above rates apply). You will never be charged for a phone call, without your provider discussing it first. If a patient is abusing access to their provider's phone or e-mail address, this may result in termination of care, at the provider's discretion. Social media is not an acceptable form of communication for current or former patients (no exceptions). **Texting is never an appropriate form of communication and business lines may not accept texts. Furthermore, your provider is not responsible for responding to any information sent via text.**

Patient Signature:

Rittenhouse
PSYCHIATRIC ASSOCIATES

Emergencies

If you have an emergency (such as an allergic reaction to medicine, suicidal thoughts with plan to act or a suicide attempt) you must call 911 or go to your nearest emergency room. This is a requirement, as we are not able to be available at all times and emergencies require immediate attention. After doing so, call your provider's emergency number listed below & share it with any providers assisting you (in the ER or Crisis Center etc.).

Emergency Lines: These lines may not accept texts, and we are not responsible for any information texted to them:

J. Plocher CRNP: 267-358-6157
R. Reis, CRNP: 609-722-6787
K. Joffe, CRNP: 484-320-7475
L. Carone, MA: 215-913-9082
E. Wray, CRNP: 215-914-5860

E. Milburn CRNP: 267-737-8039
S. Mendelovich, BSW: 484- 533-7167
L. Sernekos, PhD, CRNP: 856-563-4792
G. Yeo, MD: 484-380-5634

C. Pagnani MD: 267-275- 4381 R.
D'Amato, CRNP: 610-719-3114
K. Spano, Psy.D.: 267-422-2243
K. Chen, CRNP: 267-270-5129

We are not always available even when calling these numbers (this is why it is vital that you call 911 or go to your nearest emergency room first). If you have any concerns about this policy, you are required to discuss with your provider (at the initial evaluation or if you develop concerns during your course of treatment). **Our providers do not have admitting privileges at local hospitals, a dedicated emergency line, or support staff answering phones during evenings, holidays and weekends. We have the resources to see patients with moderate levels of mental illness, and to be available within 48 business hours for patient needs. If a patient requires an inpatient psychiatric admission, has a suicide attempt, or an act of self-harm, this is typically an indication that they would benefit from a provider with additional emergency resources. If this occurs, patients will need to work with their treatment team (if inpatient) or utilize resources that their provider at RPA offers them, to find a new provider that is more appropriate for their care. Safety is extremely important to us, and it is incredibly important that we are transparent about our capabilities, resources and competencies, and only practice within them.**

Signature of Patient: _____

Automatic (Robotic) Text Message Appointment Reminders

Our office utilizes an Automatic (Robotic) text message appointment reminder system. Please sign below if you would like to opt-in for this service (standard text charges through your carrier will apply). If you decide to opt-out, your provider will exclude you from this service. We do not receive replies to these messages.

You can also cancel this service by replying [**STOP**] to any automatic message from our office.

TYPE **YES** HERE TO OPT IN,

TYPE **NO** HERE TO OPT OUT:

Rittenhouse
PSYCHIATRIC ASSOCIATES

TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, email, patient portals and remote patient monitoring are all considered telehealth services.

Patient Name:_____ Date of Birth:

1. I understand that telehealth involves the communication of my medical and mental health information in an electronic or technology assisted format (phone, videoconferencing and others).
2. I understand that I may opt out of telehealth visits at any time. This will not change my ability to receive future care at Rittenhouse Psychiatric Associates, but may affect my ability to see my current provider.
3. I understand that telehealth services can only be provided to patients, including myself, who are physically located in the state of Pennsylvania, at the time of their visits. If my provider is also licensed in New Jersey (or another state), then I may also have telehealth visits, when I am physically located in that state as well (it is my responsibility to discuss with Rittenhouse Psychiatric Associate's staff, where my provider is licensed, and it is my responsibility to notify them, should I no longer be able to have appointments from a state where my provider is licensed).
4. I understand that telehealth billing information is collected in the same manner as regular office visits, and visit fees are the same for face-to-face visits and telehealth visits at Rittenhouse Psychiatric Associates.
    a. I understand that if technology fails for a videoconferencing session, the visit will be moved to a phone appointment, and there will be no change in visit fees (I will still be responsible for the full visit fee).
5. If I have out-of-network health insurance benefits for mental health services, it is my responsibility to discuss with my insurance company, whether they reimburse for telehealth appointments. Our fees do not change whether a patient's insurance company accepts telehealth as a reimbursable expense, and it is my responsibility to research before making appointments with this office.
6. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
    a. It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.

b. Electronic systems that are accessed by employers, friends or others are not secure and should be avoided. It is important for me to use a secure network.
c. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
d. Telehealth visits could be "hacked," despite reasonable efforts being made to prevent this from occurring.
e. Providers will not be able to perform a true physical examination, check vital signs or take other actions, that may be part of the standard of care, for the prescription of certain medications or when assessing patients with certain presentations or conditions. If my provider recommends that I purchase a blood pressure cuff and record data, see my primary care physician for vitals or take other actions to mitigate the risk of an adverse outcome because of this, it is my responsibility to do so, and I acknowledge that not doing so, may result in physical harm to me or an adverse outcome.

7. I agree that information exchanged during my telehealth visit will be maintained by doctors, nurse practitioners, therapists, administrators, and other providers involved in my care.
8. I understand that medical information, is governed by federal and state laws that apply to telehealth.
9. I understand that Skype, FaceTime or similar services may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed. If I have questions pertaining to the platform that my provider is using, it is my responsibility to discuss with my provider and/or Rittenhouse Psychiatric Associate's staff, before any telehealth appointments.
10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications with others.
11. The healthcare provider is not responsible for breaches in confidentiality caused by an independent or third party or by me.
12. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may result in the termination of my telehealth visit.
13. I understand that I have the responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
14. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
15. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a patient, I agree to accept responsibility for following my healthcare provider's recommendations- including further diagnostic testing, such as lab testing or an in-office visit.
16. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted

diseases, mental health information and addiction treatment (alcohol and drug use, abuse and dependence for example).

17. I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communication.
18. By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
19. I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
20. To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
21. **I understand that electronic communications should never be used for emergency communications or urgent requests. In the case of an emergency, I will call 911. Telecommunications (including email) are never to be used in the case of an emergency. Additionally, text is never an appropriate form of communication with any of our providers, and we are not responsible for responding to any texts.**
22. If a potential new patient has a history of psychiatric inpatient admission, suicide attempts or psychosis, we will not be able to provide virtual visits (as we believe that it may be safer to have a provider whom these patients can see face-to-face on a regular basis).
23. If during the course of treatment, a patient's provider deems that they do not have the skill-set or resources to safely provide care to a patient virtually or otherwise (for example, if a patient is assessed as being high risk for self-harm or suicide) the provider will discuss this directly with the patient, provide resources on finding local mental health professionals (for example, providers whom the patient can see for regular face-to-face appointments, with admitting privileges at local psychiatric hospitals and 24-hour emergency coverage), and the patient will be required to transition to a new provider within 90 days; it's important to our practice that we are honest with our patients, and if we do not feel that we are not only a good fit medically, but a SAFE fit, a transition of care will be required. It is the patient's responsibility to make an appointment with another provider and to follow through with this transition of care. Our providers will provide medical records and/or a summary of care to your new provider, with a signed release of information upon your request.
24. If a patient is being seen for addiction, an initial face-to-face visit may be required, and patients will be required to have random drug screens performed within 72 hours of a provider's request, throughout care. If a patient is abusing alcohol or benzodiazepines (Xanax, Valium, Klonopin, Ativan) the provider may require continued face-to-face appointments, for safety purposes, at their discretion. Additionally, your insurance company may not reimburse for telehealth visits.

I certify that I have read and understand the Telehealth Informed Consent agreement and that all of my questions have been answered to my satisfaction.

I agree to electronic communication between all staff at Rittenhouse Psychiatric Associates / Chris Pagnani MD PC and myself:

What state will you be physically in during your telehealth visits? It MUST be a state in which your provider is licensed: