

Henry C. Skinner, M.D.
Family Psychiatry of Maine, PA, LLC
253 Main St.
Yarmouth ME 04096

Phone 207-650-1393
Fax 888-538-7919
familypsychiatry@proton.me
www.familypsychiatry.me

TREATMENT AGREEMENT

I, _____ hereby consent to
evaluation and treatment by Dr. Henry Skinner/Family Psychiatry of Maine for the following concern(s):

_____.

Right to Consent: I certify that I am an independent adult legally entitled to consent for treatment, and that no other person is legally entitled, authorized or required to consent to my treatment. _____

Risks and Alternatives: I may expect that Dr. Skinner will explain his assessment and/or diagnosis and any further recommended diagnostic interventions, including the potential risks and benefits. I may expect that Dr. Skinner will explain the risks and benefits of the recommended treatments, including alternative treatments and no treatment. _____

Therapy Risks: I understand that Dr. Skinner may have ideas about my condition that are uncomfortable to discuss or with which I may disagree. I accept that the discussion and implementation of these findings and recommendations may cause short-term emotional distress in the service of lasting improvement. _____

Medication Risks: All medications carry a potential for side effects as well as benefits. I may expect that if Dr. Skinner recommends medications, he will explain the possible risks, expected benefits and alternatives, including no medication. Dr. Skinner will inform me of common and serious side effects which sometimes occur, but it is not practically possible to cover all possible side effects. If anything occurs that I am concerned may be a side effect of the medication, I agree to contact Dr. Skinner. _____

Mandated Reporting: I understand that Dr. Skinner is obligated by law to report any concerns of physical, sexual and/or emotional abuse and/or neglect to the appropriate authorities. The appropriate authorities have responsibility for evaluating and substantiating (or not) concerns of abuse and/or neglect. Furthermore, United States Supreme Court rulings require that if a patient makes a threat of violence against an identifiable individual, that person and the police in their jurisdiction are required to be notified. _____

Privacy and Confidentiality: I have a right to expect confidentiality in my relationship with the psychiatrist. Indeed, trust is a fundamental ingredient of a successful treatment. However, there are situations in which confidentiality may have to be breached, such as the following:

- In event that Dr. Skinner has a concern that abuse of a minor or elder is taking place, he is required by law to report it to DHHS. DHHS will evaluate whether the concern is substantiated. _____
- In the event that the patient makes a specific threat against an identifiable individual, that individual and the police in their jurisdiction are required to be notified. _____
- In the event that a patient is at risk of significant self-harm or harm to others or is impaired by mental illness to the point that they are unable to adequately care for themselves, they may be involuntarily hospitalized. This would, of course, require notifying appropriate crisis resources such as 988, the ER, and the hospital. _____
- The medical records may be subject to subpoena in the event of a legal action (in which case they would become permanently available as part of the public record). _____

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Boundaries: For effective treatment to take place, we can have only one kind of relationship: that of doctor and patient. We may have no other personal or business relationship. I do not accept gifts of any size or value. If you desire to express gratitude, cards or positive online reviews are appreciated. _____

Contacting the clinic:

For practical and logistical, non-urgent issues such as appointment scheduling, billing, or medication refill requests, I will use email, phone, or the secure texting app **Signal Messenger**. I will download Signal for free from the Apple Store or Google Play. _____

I acknowledge that email does NOT meet standards for medical privacy and I accept the risk of privacy breach if I communicate with Family Psychiatry of Maine by email. _____

I acknowledge that regular texting offers **NO PRIVACY OR CONFIDENTIALITY WHATSOEVER**, that my cell phone carrier will keep a record of the content of all my texts and that anyone can see my texts by looking at my phone. I accept all the responsibility for all the risks of privacy breach if I communicate with Family Psychiatry of Maine by regular texting. I will hold Dr. Skinner and Family Psychiatry of Maine harmless for any and every damage or liability associated with the use of regular texting. _____

For clarity and confidentiality, all discussion of clinical matters should take place in person, over the phone, or by secure video connection (“telehealth”). You may reach Dr. Skinner’s confidential voicemail, and you should leave a message about your concern. Dr. Skinner will try to return the call within one business day. _____

Emergencies: If you are having an emergency during business hours, call me. If patients are having thoughts of dying, suicide, or self-harm, this is an emergency. If you get my voicemail and I do not call back within 10 minutes, or it is outside business hours, you should do one of the following:

- Call 988 or 911
 - Go to your nearest emergency Room
- _____

Refills: Patients/Parents/Guardians have a responsibility to track their medication supply. Refill requests will be made 3 business days in advance, otherwise they may not get filled in time. _____

Scheduling and Cancellations: After the initial evaluation, scheduling is done at the time of the visit, by email, Signal or phone. Cancellations on less than 24 hours’ notice will be charged 50%, unless a valid reason is presented. _____

For Anthem and Mainecare members only: the above cancellation policy does not apply. Instead, patients who cancel on short notice or fail to show up 3 or more times may be discharged from the practice on 30 days notice.

By providing insurance information, you consent to have billing information, including diagnosis codes, sent to the insurance carrier for claims processing and you assign reimbursement to Family Psychiatry of Maine.

Insurance carrier: _____ **Insurance ID #** _____

Subscriber name: _____

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Fees & Payments: the basic rate is \$300 per hour.

- Initial evaluation (60 minutes) is \$300.
- 50 minute sessions are \$300
- 25 minute sessions are \$150
- Other services, such as participating in meetings, writing letters, completing forms, or phone calls are billed by the hour in 15 minute increments.

To cover payments, copayments, deductibles, no-show fees or other costs, you will need to leave payment information on file. This may be a credit or debit card. Family Psychiatry of Maine will be happy to furnish receipts for your records or insurance reimbursement needs. _____

Signature of patient: _____

Print Name: _____

Date: _____ relationship: _____

Henry Skinner, MD: _____ Date: _____