

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



TREATMENT AGREEMENT

I/We, _____ and _____,

bring my/our child _____ to Family
Psychiatry of Maine/Dr. Henry Skinner for evaluation and/or treatment of the following concern(s):

_____.

Each parent/guardian must read and initial each paragraph

Right to Consent: By my signature below, I/we certify that I am/ we are legally entitled to consent for medical treatment of this child, and that no other person is legally entitled, authorized or required to consent to this 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/our child's condition that are uncomfortable to discuss or with which I/we may disagree. Furthermore, I understand that treatment of children's issues usually involves other family members in addition to the identified patient. Treatment often requires behavioral change by both the child as well as other family members. It is possible that evaluation and treatment of family members other than the identified child may be recommended. I accept that the discussion and implementation of these changes may cause short-term emotional distress in the service of lasting improvement. _____ & _____

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

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



Privacy and Confidentiality: Both you and your child, if age 14 or older, have a right to expect confidentiality in your 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.

- 1) In event that Dr. Skinner has a concern that abuse is taking place, he is required by law to report it to DHHS. DHHS will evaluate whether the concern is substantiated. _____ & _____
- 2) In the event that the patient or a family member makes a specific threat against an identifiable individual, that individual and the police in their jurisdiction are required to be notified. _____ & _____
- 3) 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 or 911, the ER, and the hospital. _____ & _____
- 4) I/we may expect that Dr. Skinner will keep parents/guardians fully informed if he has concerns that a patient is at imminent risk for such behavior, unless he it is his judgement that so informing the parents/guardians will exacerbate the risk. _____ & _____
- 5) The medical records may be subject to subpoena in the event of a legal action (in which case they would become public record). _____ & _____

Boundaries: In order for effective treatment to take place, we can have only one kind of relationship: that of doctor and patient(s). 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 much 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 Messenger for free from the Apple Store or Google Play. _____ & _____

By initialing this paragraph, we indicate your understanding that email does NOT meet standards for medical privacy and we accept the risk of privacy breach if we communicate with Family Psychiatry of Maine by email. _____ & _____

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

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



For clarity and confidentiality, all discussion of clinical matters should take place in person, over the phone, or by secure video connection (“telehealth”). When we reach Dr. Skinner’s confidential voicemail, we will leave a message about our 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 98 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 commercial insurance 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 diagnosis codes sent to the insurance carrier for claims processing and you assign reimbursement to Family Psychiatry of Maine _____ & _____

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

- Initial evaluation (90 minutes) is \$450.
- 50 minute sessions are \$300
- 25 minute sessions are \$150
- Other services, such as participating in IEP meetings, writing letter, completing forms or communications with insurers, are billed by the hour in 15 minute increments.
- Short-notice-cancellation and no-show fee: 50% of the anticipated charge.

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. _____ & _____

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



Signature of patient/parent/guardian: _____

Print Name: _____

Date: _____ relationship: _____

Signature of second parent/guardian: _____

Print Name: _____

Date: _____ relationship: _____

Signature of patient age 14 through 17: _____

Print Name: _____

Date: _____