

Ilona Csapo, MD
Psychiatrist and Addictionologist

Information for Clients, Informed Consent and Agreement
Outpatient Psychiatry and Substance Use Disorder Treatment Services
25 Orange Street, Asheville, NC 28801
Phone: 828-772-6715 | Fax: 828-378-0223

Provider Qualifications

Dr. Ilona Csapo received her Doctor of Medicine degree in 2002 from Dartmouth Medical School in Hanover, NH. She completed a general psychiatry residency at the University of New Mexico in Albuquerque, NM in 2006 and has been a certified Suboxone provider since 2004. Dr. Csapo is board certified with the American Board of Psychiatry and Neurology and the American Board of Addiction Medicine. She is a member of the American Psychiatric Association and the North Carolina Medical Society.

Fees and Length of Service

Initial Psychiatric Assessment Appointment - \$200
Medication Management Follow-Up - \$115

Initial payment is due at the time of the first appointment and at each subsequent, monthly follow-up appointment. Forms of payment accepted are cash, check and credit card. When using a credit card, a \$5 surcharge applies.

Insurance

At this time, I am paneled with **Blue Cross Blue Shield**. For other insurance plans, I am happy to provide a "superbill" that you can submit to your insurance company for out-of-network benefits. Because insurance plans vary widely, you will need to consult with your policy to determine coverage and benefits.

Diagnosis

Most insurance companies require a diagnosis of a mental-health or substance use disorder condition before they will agree to reimburse you. If a qualifying diagnosis is appropriate in your case, I will inform you of the diagnosis before we submit the diagnosis to the health insurance company. Any diagnosis made will become part of your permanent insurance records.

Social Media/ Electronic Communication Policy

Email, texting, and other social media platforms are features of 21st century life. Cellular phone and Internet communication provide quick and effective ways to communicate. However, it is very important to be aware of the risks of these types of communication, particularly the difficulty of maintaining the confidentiality of electronically transmitted communications, including email, texting, and other social media formats, and that using these technologies could risk your privacy. Social media pages are not intended for clinical interaction with current or prospective clients. Professional ethics explicitly prohibit me from "friending" or interacting with clients on any personal social media accounts.

Scheduling and Cancellations

Sessions are available by appointment on Tuesday, Wednesday and Saturday. There is no charge for cancellations made at least 24 hours before your appointment time. A \$25 fee is charged for no-shows and cancellations with less than 24 hours notice.

Confidentiality

Pursuant to HIPAA and Federal Law 42 CFR, all of our communication becomes part of the clinical record, which is accessible to you upon request. I will keep confidential anything you say as part of our treatment relationship, with

the following exceptions: (a) you direct me in writing to disclose information to someone else, (b) it is determined you are a danger to yourself or others (including child or elder abuse), or (c) I am ordered by a court to disclose information.

Client Rights: HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that I amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about my policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the Notice form, and the privacy policies and procedures. I am happy to discuss any of these rights with you. In the case of my death or major medical incapacitation, all records will be accessed by Kimberly Skelton, LPCS, LCAS.

Right to Refuse Service and/or Refer

We reserve the right to refuse service and/or offer referral options if it is determined this practice may not best serve patient needs. This may be based on safety concerns, patient presenting as hostile, disruptive or intoxicated/high or due to non-compliance with treatment contract, etc.

Scheduling and Hours

Appointments are scheduled in advance & require 24 hrs notice of cancellation. After the first missed appointment, clients will be billed at the full rate.

After Hours Support and Emergencies

This practice does not provide emergency services. If you are in need of emergency services, you have the following options: 1) Go to the closest ER or call 911; 2) Contact Mobile Crisis at 1-888-573-1006 for 24/7/365 Crisis Response; or 3) Contact Vaya Health at 1-800-849-6127 at any time. Voicemails are checked daily Monday-Friday and calls are returned within 24-48 hours.

Complaints

Although clients are encouraged to discuss any treatment concerns with us, you may file a complaint with the relevant licensing board should you feel your provider has been in violation of provider's code of ethics.

North Carolina Medical Board | PO Box 20007, Raleigh, NC, 27619-0007 | 919-326-1100 or 919-326-1109

Acceptance of Terms

We agree to these terms and will abide by these guidelines.

Client Signature: _____ Date: _____

Psychiatrist Signature: _____ Date: _____

Signature of Parent/Guardian if Client is a Minor: _____ Date: _____

Ilona Csapo, MD, PLLC
New Patient Information

Today's Date: ____/____/____

Name: _____ Soc Sec #: _____ - _____ - _____ Birth Date: ____/____/____

Sex: ____ Race: ____ Marital Status: ____ Employer: _____ How did you hear about us? _____

Home phone#: _____ Ok to leave message? ____ Cell phone #: _____ Ok to leave voicemail? ____

Ok to sent text message? ____ Email: _____ Ok to send email? ____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact Name and phone number: _____

Insurance Carrier: _____ Subscriber Name: _____ Relationship to you: _____

Subscriber ID: _____ Group #: _____ Date Issued: ____/____/____

Medical History

Current medications: _____

Drug allergies: _____

Previous psychiatric and/or substance use disorder treatment: _____

Illnesses: _____

Surgeries: _____

Primary physician and contact information: _____

Are you pregnant? YES NO If so, how many months? _____ Who is your doctor? _____

Do you smoke? YES NO If so, how many per day? _____

Mark if you have had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Gastrointestinal problems | <input type="checkbox"/> Endocrine problems |
| <input type="checkbox"/> Cardiovascular problems | <input type="checkbox"/> Genitourinary problems | <input type="checkbox"/> Alcohol or drug problems |
| <input type="checkbox"/> Respiratory problems | <input type="checkbox"/> Vascular problems | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Musculoskeletal problems | <input type="checkbox"/> Ear/Nose or Throat problems | |

Family history of substance abuse, medical or psychiatric conditions: _____

Client Signature: _____ Date: _____

Psychiatrist Signature: _____ Date: _____

Signature of Parent/Guardian if Client is a Minor: _____ Date: _____

CLIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insurance Portability and Accountability Act (HIPAA) has created new client protections surrounding the use of protected health information. Commonly referred to as the “medical records privacy law,” HIPAA provides client protections related to the electronic transmission of data (the transaction rules), the keeping and use of client records (“privacy rules”), and storage and access to health care records (“the security rules”). HIPAA applies to all health care providers, including mental health care, and providers and health care agencies throughout the country are now required to provide clients a notification of their privacy rights as it relates to their health care records. You may have already received similar notices such as this one from your other health care providers.

As you might expect, the HIPAA law and regulations are extremely detailed and difficult to grasp if you don't have formal legal training. My Client Notification of Privacy Rights is my attempt to inform you of your rights in a simple yet comprehensive fashion. Please read this document as it is important you know what client protections HIPAA affords all of us. In mental health care, confidentiality and privacy are central to the success of the therapeutic relationship and as such, you will find I will do all I can to protect the privacy of your mental health records. If you have any questions about any of the matters discussed in this document, please do not hesitate to ask me for further clarification.

By law, I am required to secure your signature indicating you have received the Client Notification of Privacy Rights Document. Thank you for your thoughtful consideration of these matters.

I, _____, understand and have been provided a copy of the Client Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information, as well as my rights on these matters. I understand I have the right to review this document before signing this acknowledgment form.

Client or Parent Signature (if client is a minor)

Date

Provider

Date

PRIVACY PROTECTION NOTICE

THIS NOTICE DESCRIBES HOW YOUR MENTAL HEALTH RECORDS MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

This notice shall go into effect January 1, 2013 and remain so unless new notice provisions effective for all protected health information are enacted accordingly.

I. Preamble

A recent United State Supreme Court decision held that communications between providers and their clients are privileged and, therefore, are protected from forced disclosure in cases arising under federal law. There is a difference between privileged conversations and documentation in your mental health records. Records are kept documenting your care as required by law, professional standards, and other review procedures. HIPAA very clearly defines what kind of information is to be included in your "Designated Medical Record" as well as some material, known as "Psychotherapy Notes" which is not accessible to insurance companies and other third-party reviewers and in some cases, not to the client himself/herself. HIPAA provides privacy protections about your personal health information, which is called "protected health information" (PHI) which could personally identify you. **PHI consists of three (3) components: treatment, payment, and health care operations.**

Treatment refers to activities in which I provide, coordinate or manage your mental health care or other services related to your mental health care. Examples include a psychiatry session, psychological testing, or talking to your primary care physician about your medication or overall medical condition.

Payment is when I obtain reimbursement for your mental health care. The clearest example of this parameter is filing insurance on your behalf to help pay for some of the costs of the mental health services provided you.

Health care operations are activities related to the performance of my practice such as quality assurance. In mental health care, the best example of health care operations is when utilization review occurs, a process in which your insurance company reviews our work together to see if your care is "really medically necessary."

The **use** of your protected health information refers to activities my office conducts for filing your claims, scheduling appointments, keeping records and other tasks within my office related to your care. **Disclosures** refer to activities you authorize which occur outside my office such as the sending of your protected health information to other parties (i.e., your primary care physician, the school your child attends).

II. Uses and Disclosures of Protected Health Information Requiring Authorization

The law requires authorization and consent for treatment, payment and healthcare operations. I may disclose PHI for the purposes of treatment, payment and healthcare operations with your consent. You have signed this general consent to care and authorization to conduct payment and health care operations, authorizing me to provide treatment and to conduct administrative steps associated with your care (i.e., file insurance for you). Additionally, if you ever want me to send any of your protected health information of any sort to anyone outside my office, you will always first sign a specific authorization to release information to this outside party. A copy of that authorization form is available upon the request. The requirement of your signing an additional authorization form is an added protection to help insure your protected health information is kept strictly confidential. An example of this type of release of information might be your request that I talk to your child's schoolteacher about his/her ADHD condition and what this teacher might do to be of help to your child. Before I talk to that teacher, you will have first signed the proper authorization for me to do so.

There is a third, special authorization provision potentially relevant to the privacy of your records: my psychotherapy notes. In recognition of the importance of the confidentiality of conversations between psychotherapist-client in treatment settings, HIPAA permits keeping separate "psychotherapy notes" separate from the overall "designated medical record."

"Psychotherapy notes" cannot be secured by insurance companies nor can they insist upon their release for payment of services as has unfortunately occurred over the last two decades of managed mental health care. "Psychotherapy notes" are my notes "recorded in any medium by a mental health provider documenting and analyzing the contents of a conversation during a private, group or joint family counseling session and separated from the rest of the individual's medical record."

"Psychotherapy notes" are necessarily more private and contain much more personal information about you hence, the need for increased security of the notes. "Psychotherapy notes" are not the same as your "progress notes" which provide the following information about your care each time you have an appointment at my office: medication prescriptions and monitoring, assessment/treatment start and stop times, the modalities of care, frequency of treatment furnished, results of clinical tests, and any summary of your diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Certain payors of care, such as Medicare and Workers Compensation, require the release of both your progress notes and my psychotherapy notes in order to pay for your care. If I am forced to submit your psychotherapy notes in addition to your progress notes for reimbursement for services rendered, you will sign an additional authorization directing me to release my psychotherapy notes.

Most of the time I will be able to limit reviews of your protected health information to only your “designated record set” which include the following: all identifying paperwork you completed when you first started your care here, all billing information, a summary of our first appointment, your mental status examination, your individualized, comprehensive treatment plan, your discharge summary, progress notes, reviews of your care by managed care companies, results of psychological testing, and any authorization letters or summaries of care you have authorized me to release on your behalf. Please note that the actual test questions or raw data of psychological tests, which are protected by copyright laws and the need to protect clients from unintended, potentially harmful use, are not part of your “designated mental health record.”

You may, in writing, revoke all authorizations to disclose protected health information at any time. You cannot revoke an authorization for an activity already done that you instructed me to do or if the authorization was obtained as a condition for obtaining insurance and the insurer has the right to contest the claim under the policy.

III. Business Associates Disclosures

HIPAA requires that I train and monitor the conduct of those performing ancillary administrative service for my practice and refers to these people as “Business Associates.” I do employ business associates to assist with my administrative matters and these business associates are indeed trained and monitored so that your privacy is ensured at all times.

IV. Uses and Disclosures Not Requiring Consent nor Authorization

By law, protected health information may be released without your consent or authorization for the following reasons:

- Child Abuse
- Suspected Sexual Abuse of a Child
- Adult and Domestic Abuse
- Health Oversight Activities (i.e., licensing board for Professional Counselors in Georgia)
- Judicial or Administrative Proceedings (i.e., if you are ordered here by the court)
- Serious Threat to Health or Safety (i.e., out “Duty to Warn” Law, national security threats)
- Workers Compensation Claims (if you seek to have your care reimbursed under Workers Compensation, all of your care is automatically subject to review by your employer and/or insurer(s).

I never release any information of any sort for marketing purposes.

V. Client’s Rights and My Duties

You have a right to the following:

- The right to request restrictions on certain uses and disclosures of your protected health information, which I may or may not agree to, but if I do, such restrictions shall apply unless our agreement is changed in writing;
- The right to receive confidential communications by alternative means and at alternative locations. For example, you may not want your bills sent to your home address so I will send them to another location of your choosing;
- The right to inspect and receive a copy of your protected health information in my designated mental health record set and any billing records for as long as protected health information is maintained in the records;
- The right to amend material in your protected health information, although I may deny an improper request and/or respond to any amendment(s) you make to your record of care;
- The right to an accounting of non-authorized disclosures of your protected health information;
- The right to a paper copy of notices/information from me, even if you have previously requested electronic transmission of notices/information; and
- The right to revoke your authorization of your protected health information except to the extent that action has already been taken.

For more information on how to exercise each of these aforementioned rights, please do not hesitate to ask me for further assistance on these matters. I am required by law to maintain the privacy of your protected health information and to provide you with a notice of your Privacy Rights and my duties regarding your PHI. I reserve the right to change my privacy policies and practices as needed with these current designated practices being applicable unless you receive a revision of my policies when you come for your future appointment(s). My duties as a Licensed Professional Counselor on these matters include maintaining the privacy of your protected health information, to provide you this notice of your rights and my privacy practices with respect to your PHI, and to abide by the terms of this notice unless it is changed and you are so notified. If for some reason you desire a copy of my internal policies for executing private practices, please let me know and I will get you a copy of these documents I keep on file for auditing purposes.

VI. Complaints

I am the appointed “Privacy Officer” for my practice per HIPAA regulations. If you have any concerns of any sort that my office may have compromised your privacy rights, please do not hesitate to speak to me immediately about this matter. You will always find me willing to talk to you about preserving the privacy of your protected mental health information. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

Ilona Csapo, MD
Authorization for Release of Protected Health Information

Patient Name: _____ DOB: ____/____/____ SSN: ____-____-____

Person or Facility to Disclose/Receive to or from: _____

Address: _____

Phone Number: _____ Fax Number: _____

I am either the person named above or someone who can legally act for the person. I hereby authorize Ilona Csapo, MD to disclose to, receive from and communicate with the following person or facility in written, verbal and/or electronic format:

INFORMATION THAT MAY BE RELEASED/SHARED:

___ **Complete Health Record** which may include demographic information, reason for referral, alcohol/drug and legal history, urinalysis and breathalyzer results, psychiatric evaluations, medication records, progress notes, attendance and progress in treatment, assessment results or diagnoses, service or treatment plan, discharge information) including information about communicable diseases such as HIV or other sexually transmitted diseases

OR

___ **My health information about the following treatment or condition:** _____

Please check ONE: My health information for ___ **ALL DATES** or ___ **ONLY THE FOLOWING DATES:** _____

Reason: ___ Provide continuity of care ___ Compliance with program ___ Personal Use ___ Legal Purposes
___ Social security/disability ___ Insurance/Managed care ___ Other _____

- If I elect to use insurance, I understand that staff will communicate with my insurance company to provide information needed for me to utilize my insurance benefits.
- I understand that office staff coordinate care with designated pharmacy and lab.
- I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information (Title 45 of the Code of Federal Regulations, Parts 160 and 164), the Federal Rules for Confidentiality of Alcohol and Drug Abuse Patient Records (Title 42 of the Code of Federal Regulations, Chapter I, Part 2), and/or state laws. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by the Federal privacy regulations.
- I understand that I may revoke this authorization at any time by notifying my treatment provider in writing, but if I do, it will not have any effect on any actions providers took before it received the revocation. Otherwise, this release of information is valid for one year from the signed date.

Patient Signature: _____ **Date:** ____/____/____

If you are not the patient, please state your authority to act for the patient: _____

Staff Signature: _____ **Date:** ____/____/____

Date this authorization was revoked, if applicable: ____/____/____