Renee Richker, MD
Child and Adolescent Psychiatry
5738 Olde Wadsworth Blvd.
Arvada, CO 80002
303-425-1011

Dear Patient/Parent of Prospective Patient;

In order that the very best use of time and resources is made during my consultation with you, I enclose to you the following documents; this letter, Introductory Report, and Consent Form. *These documents must be completed and returned to me prior to my offering an appointment.*

Professional Information:

I am a Diplomate of the American Board of Psychiatry and Neurology and have completed a fellowship at the University of Colorado in Child and Adolescent Psychiatry. At this point I prefer to see primarily child and adolescent patients. I provide medication consultation and management and do not provide psychotherapy. I do have relationships with many excellent psychotherapists in different areas of Denver and Boulder, however, and work collaboratively in these relationships. Most of the time I strongly recommend that the child/adolescent be in treatment with a psychotherapist while their medications are being managed by me. Studies have shown faster and more enduring improvement in these treatment settings, than when a patient only takes medication alone. If you need help contacting a psychotherapist while you are waiting for your first appointment with me, please call my voice mail and I will help you choose someone appropriate.

Practice and Insurance Information:

I have a limited practice at this point. I work Tuesdays, Wednesdays and Thursdays, generally between 8:30 and 3:00pm. I sincerely apologize for the inconvenience, and understand this may require taking children out of school intermittently.

Payment if required at the time of service. Co-pays that are not paid at the time of service will be assessed a late fee if not paid at time of service. I am on two insurance panels; Mines and Associates, and United Behavioral Health/Pacificare. For any other insurance I am considered “out of network”. When I am “out of network” the patient pays me in full at the time of service, and then may get reimbursed through their insurance company. *Please contact your insurance company before your first appointment to fully understand your insurance situation thoroughly.* It is the patient’s responsibility to obtain authorization for sessions. 24 hour notification is required for cancellation of appointments. Appointments not cancelled 24 hours in advanced will be billed to the patient, and must be paid before further appointments will be set. My fee is $200 per hour and $100 per ½ hour session.

Consent/Introductory Report: Please read and complete the appropriate section.

NOTICE OF PRIVACY PRACTICES

PURPOSE:

The office of Renee Richker, MD is required by law to maintain the privacy of Protected Health Information (PHI) and to provide individuals with notice of our legal duties and privacy practices in accordance with the Health Insurance Portability and Accountability Act. This Notice is yours. The office of Renee Richker, MD, will abide by the terms of the notice currently in effect. You may obtain a copy of the notice upon request. If you are currently a patient in this practice and the notice changes, you will receive an updated Notice at that time.

USES AND DISCLOSURES:

Your Protected Health Information may be used by this office for the purposes of Treatment, Payment, and Health Care Operations (TPO).

FOR EXAMPLE:
For the purpose of treatment: Renee Richker, MD, will review, modify and summarize your health information in order to develop and carry out a treatment plan.
For the purpose of payment: Renee Richker, MD contracts with the firm of Linda Fangman and Associates, LLC to formulate your bill, bill your insurance company, (if appropriate), and certify and verify insurance benefits. In addition, if you are a member of a group health plan, your HMO or PPO may request summaries of your treatment, diagnosis, medications, compliance issues, symptoms and progress, and I will honor that request unless the patient or representative notifies me otherwise.
For the purpose of Health care operations: Linda Fangman and Associates, LLC also staffs a receptionist who makes appointments and occasionally communicates with your insurance provider. That individual will know only that information which is necessary for carrying out those duties. If that arrangement is not satisfactory to you, I will honor the request to carry out those procedures otherwise, or I will refer you to another provider.

YOUR RIGHTS

Under HIPAA, you have the right to request restriction on certain uses and disclosure of your health information. For example, you may request that copies of your treatment plan or diagnostic formation go to another provider (your PCP or Therapist, for example) but ask me to withhold particular aspects of that information. While the law does not require me to honor those requests, it does require that, if I agree to it, I must abide by our agreement except in cases of medical emergency, or by court order.

You have the right to confidential communication. You may request that myself or Linda Fangman and Associates, LLC communicate to you by alternative means or at an alternative location. You have the right to request and receive a copy of your own health care information, except for information contained in psychotherapy notes or information

compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances.

Under HIPAA, you also have the right, with some exceptions, to amend health care information maintained in my records, and to request and receive an accounting of disclosures of your health related information made by myself or my office staff during the six years prior to your request. (Please note that the accounting requirement becomes effective 4/14/03). You have a right to receive a paper copy of t his notice upon request.

WHAT IF MY HEALTH INFORMATION NEEDS TO GO SOMEWHERE ELSE?
You may request that I send your health information somewhere else. An "authorization to Release/Request Information" or equivalent must be completed. You can cancel or limit the amount of information sent at any time by letting use know in writing. Your authorization otherwise remains in effect for 90 days after signing.

If you are less than 15 years old-your parents or guardians my receive your private health information and are considered your legal representative, unless by law you are able to consent for your own health care treatment. If you are, then your private health care information will not be shared with parents or guardians unless you sign an authorization form.

COULD MY HEALTH INFORMATION BE RELASED WITHOUT MY CONSENT?
Except for the above use of information for Treatment, Payment, or Operations of this practice, release of your information will only be made without your authorization in the following circumstances:

1. Any government organization which oversees my practice.
2. In the event that we suspect abuse, neglect, or domestic violence has taken place.
3. As a "duty to warn" if you have threatened the life of another individual.
4. As required by court order of subpoena.
5. If you commit a crime on the premises or on my property.

HOW CAN IA FIND OUT IF MY HEALTH INFORMATION HAS BEEN RELEASED?
Ask for a "Request for Accounting of Disclosures Form" from this office to obtain a list of when, where and what type of information has been released from your chart in this office.

ACKNOWLEDGMENT

I hereby acknowledge that I received a copy of this notice.

________________ __________________ ________________________

Date Print Name Signature

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

I understand that as part of my (or my child's) healthcare, this organization originates and maintains health records describing my (or my child's) health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care of treatment. I understand that this information serves as:

1. a basis for planning care and treatment
2. a means of communication among health professionals
3. a source of information for applying a diagnosis for billing purposes
4. a means by which a third-party payer can verify that services billed were actually provided
5. a tool for routine healthcare operations such as assessing qualify and reviewing the competence of healthcare professionals

I understand and have been provided with a **NOTICE OF INFORMATION PRACTICES** that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

__________________________ _____________________________

Signature of patient Parent or Guardian

Notice Effective Date: April 14, 2003

_______Accepted _______Denied

Patient Name:______________________________________Date:____________________