Aparna Iyer, M.D.

Board Certified Psychiatrist

Welcome to my practice! I appreciate and value this step you have taken towards your treatment, and I look forward to working with you. I have prepared a description of my services and an explanation of my policies in order to help you better understand what to expect from me. Please read the following information and ask questions as needed.

SERVICES

I am a board-certified adult psychiatrist licensed in the state of Texas. I offer psychiatric consultation, individual psychotherapy with and without medication management, and medication management. I use evidence-based practices for both psychotherapy and psychopharmacology. I am conservative in the use of psychotropic medications and prescribe it only if clinically warranted. If you have an individual therapist, I offer medication management in close collaboration with your therapist.

PHILOSOPHY

My approach is collaborative, working together with the patient towards his or her individual goals. I am a firm believer in the therapeutic value of establishing a trusting and respectful relationship with my patients. I focus my efforts on getting to understand the patient first, with a holistic and gentle approach, prior to formulating a treatment plan. My approach is thorough, exploring a patient's biological, psychological and social factors prior to determining the next best step, which may or may not include medications.

TREATMENT APPROACH

The initial sessions typically serve to help me understand more about you and understand your current problems, concerns and needs. I will provide you my clinical impressions and initial opinions about approach to treatment. If you decide to continue to work with me for treatment, at this point I will provide you with my working understanding of the problem, as well as treatment options and therapeutic objectives. During the course of treatment, I may utilize various psychotherapeutic approaches as well as medication recommendations.

CONFIDENTIALITY

Patient confidentiality is very important to me. To ensure your confidentiality, if I see you in public, I will not acknowledge you unless you acknowledge me first.

I will not share your medical records with anyone without specific authorization and written consent from you, excepting in the following circumstances:

- In my professional opinion, you are at risk for seriously injuring or killing yourself. In this circumstance, I am ethically and legally required to work with the patient to prevent this from occurring. The plan of action could include developing a safety plan with family members or others who can help provide protection, arranging for hospitalization with a patient's consent, or in the event of an emergency, facilitating involuntary hospitalization.
- In my professional opinion, you are at risk for seriously injuring or killing someone else. In the event that there is an identifiable person or persons at risk, I would take preventative and protective

actions to protect others from harm. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization, even if involuntary, for you.

- There is reason to suspect a child, elder (age 65 or older), or a dependent adult is being neglected or abused. In these circumstances, the law requires that I file an immediate report with protective services or the appropriate state agency.
- Occasionally, I may have to consult other professionals about your illness or treatment options. During a consultation, I will make every effort to avoid revealing your identity to the consultant. The consultant is also legally bound to keep the information confidential.
- When I am unavailable (i.e., on vacation, extended sick leave, family emergency), I will provide limited information to a clinician covering for my services.
- All mental health professionals are required to keep professional records, which is critical for continuity of care. Although I will make every effort to safeguard your privacy, records may be subpoenaed by a court of law.
- I may also be obligated to disclose relevant information regarding your care in order to defend myself, should there be a complaint or lawsuit filed against me.

MEDIA AND SOCIAL MEDIA

I am active in blogging and social media. Please note that any of my opinions expressed on any form of public media, including social media (blogs, Facebook, Twitter, Instagram), are not considered to be personal medical advice. Patient advice will not be provided in media or social media and should be restricted to patient visits or telephone calls. Any references that I may make in the media or social media are never patient specific and are always generalized and fictionalized.

APPOINTMENTS AND CANCELLATION POLICY

Because every patient is important to me, I will not be able to keep other patients waiting if you are late for any reason. Therefore, I suggest that you try to be here a few minutes early so that your appointments start and end at their scheduled times.

I have a 24-hour cancellation policy. Please note that you will be responsible for payment of my fees if you cancel your appointment within 24 hours of the appointment. If I ever have to cancel your appointment with less than 24 hours-notice to you, I will waive my fee for that rescheduled appointment.

FINANCIAL POLICY

I do not accept insurance. You may pay with cash or credit card. Full payment is due at time of service.

If you plan to pay through credit card, you must complete a credit card authorization form during the initial visit. Your credit card will then be billed for regular appointments as well late cancellations and telephone services. If you change credit cards, please let us know and please provide us the information for your new credit card.

If you will be filing statements with insurance, upon request, I will provide you with the necessary statements along with the diagnosis code.

FEES

Fees for the initial consultation will be billed at $395 and will typically last for 60 minutes. For more complicated issues, additional time may be required. This is billed at $75 per 15 minute increment.

Fees for psychotherapy appointments, which include judicious treatment with psychiatric medications if indicated, will be billed at $250 and will typically last for 45 minutes. If additional time is needed, the billing will be at $75 per 15 minute increment.

Fees for medication management appointments will be billed at $175 and will typically last for 25 minutes. If additional time is needed, the billing will be at $75 per 15 minute increment. I do not fill medication requests over phone and recommend that you schedule an appointment instead.

I do not accept health insurance and am not a member of any managed care provider panels. However, I can provide you with an invoice that includes charges, payments, CPT codes and DSM-IV diagnosis codes; most insurance carriers require this information for reimbursement. You can then submit a copy of this invoice to their health insurance company for possible partial reimbursement. Rates of reimbursement vary by insurance carrier and plan. Therefore, you may wish to check with your carrier prior to scheduling an initial appointment.

TELEPHONE POLICY

I generally address clinical issues only during therapy appointments. If there is an urgent issue that you would like to discuss over the phone and the phone conversations will be longer than 10 minutes my fee will be $100 per 15 minute increment. I do not bill for any phone calls relating to scheduling or billing, or for any calls that I initiated to you myself.

MEDICATIONS POLICY

I do not fill medication requests over the phone, even in emergencies. By signing this form, patient agrees to take the medications as prescribed, not take the medications of others, and not self medicate. I reserve the right to order a drug test at any time if I think it is necessary. Please note that the state of Texas offers a prescription monitoring program that offers information on all controlled substances filled by patients. I may run this screen on you to verify the medications that you are on and from where you may be receiving these prescriptions.

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I have a 24-hour cancellation policy. Please note that you will be responsible for payment of my fees if you cancel your appointment within 24 hours of the appointment. If I ever have to cancel your appointment with less than 24 hours-notice to you, I will waive my fee for that rescheduled appointment.

LITIGATION

Due to the nature of the therapeutic process, it is agreed that should there be legal proceedings (such as, but not limited to, divorce and custody disputes, injuries, lawsuits, etc.), neither you nor your attorney(s), nor anyone else acting on your behalf will call on me to testify in court or at any other proceeding, nor will a disclosure of the psychotherapy records be requested unless we agree otherwise. In the event that you become involved in legal proceedings that mandate my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulty of legal involvement, my fee is $500 per hour for preparation, attendance, and travel to/from any legal proceedings. Record depositions, subpoenas and court appearances should be scheduled five days in advance as a courtesy to the practice and the other patients.

EMERGENCY SERVICES

I try my best to return phone calls within 24 hours. However, particularly if you have called on the weekend or during the evening hours, it might take longer than 24 hours until you are able to hear back from me. For urgent matters only, you may call me at (972) 379-7380. If you are in an emergency situation or require urgent attention, please call 911 or go to the nearest emergency center.

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I have read the practice policies notice and have been given time for questions. I understand the practice policies.

PATIENT NAME | PATIENT DATE OF BIRTH

PATIENT SIGNATURE | TODAY'S DATE

APARNA IYER, MD
6842 Lebanon Road, Suite 103, Frisco, TX 75034 | Office (972) 380-1842 | AparnaIyerMD@gmail.com

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REGISTRATION FORM

PATIENT NAME

STREET | CITY | ZIP

PHONE # PATIENT E-MAIL

PERMISSION TO CALL? PERMISSION TO E-MAIL?

PATIENT DATE OF BIRTH GENDER

EMERGENCY CONTACT

NAME RELATIONSHIP

STREET | CITY | ZIP

PHONE # E-MAIL

INSURANCE

WOULD YOU LIKE ME TO E-MAIL YOU OR HAND YOU THE INSURANCE STATEMENT?

PRIMARY INSURED PERSON'S NAME DATE OF BIRTH

PRIMARY INSURED PERSON'S STREET | CITY | ZIP

PHARMACY

PHARMACY NAME STREET | CITY | PHONE #

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CREDIT CARD AUTHORIZATION FORM

PATIENT NAME | PATIENT DATE OF BIRTH

NAME ON CARD

ACCOUNT NUMBER

TYPE OF CARD | EXPIRATION DATE | SECURITY CODE | BILLING ZIP CODE

By signing this form, you authorize Dr. Iyer to charge your card for fees as discussed due on a recurring basis, with receipts and insurance statements to be e-mailed to you.

If you change credit cards, please let us know and please provide us the information for your new credit card.

This authorization may be revoked at any time by contacting and informing Dr. Iyer via e-mail, text, telephone or in person.

YOUR NAME | SIGNATURE | TODAY'S DATE

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NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

This notice describes how your medical information can be used and disclosed and how you can get access to this information. Please review it carefully. I am committed to protecting the privacy of your medical records and the confidentiality of your visit. Your records (chart) will not be released to anyone outside of this facility without your written permission unless a release is required by law.

I WILL USE YOUR INFORMATION FOR THE FOLLOWING PURPOSES

1. Treatment - to determine your care and treatment.
2. Payment - if you file your own insurance claims and your insurance company request documentation of charges for my services, information may be released to your insurance carrier, with your permission.

DISCLOSURE REQUIRED BY LAW

1. Food and Drug Administration (FDA) -if there were a drug/product recall or defect.
2. Public Health - I may disclose your health information to public health authorities in charge of controlling disease, injury, or disability.
3. Law Enforcement – I may disclose health information in response to a valid subpoena.

YOUR HEALTH INFORMATION RIGHTS

Your health record is the physical property of Dr. Iyer's medical practice, but the information belongs to you and you have the right to the following:

1. Request a restriction on certain uses and disclosures of your information.
2. Obtain a copy of the notice of information practices (this document).
3. Inspect a copy of your health records.
4. Amend your health record as provided in 45 CFR 164.528.
5. Obtain an accounting of disclosures of your health information.
6. Request communication of your health information by alternative means or at alternative locations.
7. Revoke your authorization to use or disclose health information except for action already taken.

MY RESPONSIBILITY

1. Maintain the privacy of your information.
2. Provide you with a notice that explains our legal duties and privacy practices.
3. Abide by the terms of this notice.
4. Notify you if I am unable to agree to a restriction that you request.
5. Accommodate reasonable requests you may have to communicate health information by alternative means or locations. We reserve the right to change practices and make new provisions.

I have read the notice of privacy practices for protected health information and have been given time for questions. I understand that Dr. Iyer will not release my health information unless I give written permission or when required by law.

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AUTHORIZATION RELEASE FOR THE EXCHANGE OF CONFIDENTIAL AND PRIVILEGED INFORMATION

I hereby authorize Dr. Aparna Iyer, located at 6842 Lebanon Road Suite 103 in Frisco, TX 75034, to release and obtain the individual's protected health information to and from the following:

_____

WHO CAN RECEVE AND USE THE HEALTH INFORMATION

_____

PHONE

_____

FAX

_____

STREET ADDRESS APARTMENT/SUITE NUMBER

_____

CITY STATE ZIP CODE

I understand that this information will be used solely for the purpose of my treatment.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

I understand that even if this consent expires or is revoked, Dr. Iyer may be required to disclose information in the following situations:

1. If the patient is at imminent risk of harm to self.
2. If the patient is at imminent risk of harm to others.
3. If Dr. Iyer is subpoenaed to testify in court.
4. If Dr. Iyer suspects abuse to or neglect of a child, elderly person, or person with a disability.

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

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WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only "All health information."

___ All health information ____Physician's Orders ____Progress Notes

____Pathology Reports ____History/Physical Exam ____Patient Allergies

____Discharge Summary ____Billing Information ____Past/Present Medications

____Operation Reports ____Diagnostic Test Reports ____Lab Results

____Consultation Reports ____EKG/Cardiology Reports ____Radiology Reports&Images

____Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)

_____Drug, Alcohol, or Substance Abuse Records

_____Genetic Information (including Genetic Test Results) _____ HIV/AIDS Test Results/Treatment

REASON FOR DISCLOSURE (Choose only one option below)

____Treatment/Continuing Medical Care ____Personal Use ____Billing or Claims

____Insurance ____Legal Purposes ____Disability Determination

____School ____Employment ____Other:_____

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I affirm that I have had the opportunity to examine this authorization and that I understand the information contained and the rights and privileges I am now waiving. My signature represents my permission for Dr. Iyer to release and obtain information relevant to my treatment.

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PATIENT NAME PATIENT DATE OF BIRTH

SIGNATURE OF PATIENT OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE

TODAY'S DATE

PRINTED NAME OF LEGALLY AUTHORIZED REPRESENTATIVE (IF APPLICABLE)

IF REPRESENTATIVE, SPECIFY RELATIONSHIP TO THE INDIVIDUAL:

____PARENT OF MINOR ____ GUARDIAN ____OTHER:_____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE OF MINOR INDIVIDUAL DATE

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Covered entities, as that term is defined by HIPAA and Texas Health & Safety Code § 181.001, must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

• Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501). • Drug, alcohol, or substance abuse records.

• Records or tests relating to HIV/AIDS.

• Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also

includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.