Stacy B. Woods, M.D PC

3206 Tower Oaks Blvd. Suites 400, Rockville, MD 20852
240-283-1163

Service Agreement for Dr. Stacy Woods

General Information

Thank you for choosing me as your psychiatrist. I provide psychiatric services in the form of evaluation for and oversight of medications for the treatment of various psychiatric conditions. Initial sessions are for the purpose of assessment, and later sessions are called evaluations, and the purpose is to review how things are going and review how well the prescribed treatment is achieving the desired results. These sessions are scheduled at a time and frequency that we agree upon. Sessions are scheduled on the hour or half hour. If you are late for a session, that time may be lost from your session unless I have additional time before my next appointment. If I am late for a session, we will extend your session or we will make other arrangements by mutual consent.

The frequency of visits may vary, but often patients return for medication evaluations and prescription refills on a regular interval of every 4-6 weeks. Sessions may be scheduled more often, for example while a new medication is being taken, or if there is a concern about the impact or effectiveness of a medication.

As your doctor I will ask many questions about how you are doing and feeling, both physically and emotionally. Please feel free at all times to share any concerns or issues that you feel are relevant for your treatment.

Emergency

In the event of a medical or psychiatric emergency, please call your family physician or go to the nearest emergency room. If an urgent matter requires Dr. Woods consultation, please contact your clinician's cell phone 301-928-2006. Please leave a brief message, indicating the nature of your call, and the return phone number where the clinician can reach you. Your call will be returned as soon as possible. If you cannot reach the clinician at the time of the emergency, call 911 or go to your nearest emergency room.

Cancellations, Late Arrival, and Missed Appointments Policy

If for any reason you are unable to meet for your appointment, you are responsible for calling or sending an email to cancel at least **48 business hours prior to your scheduled time. Failure to cancel within 48 hours will result in the patient being charged a $180.00 fee for the appointment. If you do not show for 2 appointments in a calendar year you will be discharged from the practice.**

Fees and Payment Expectations

I do not accept insurance, but our administrative office will provide you with an invoice that you can submit for out-of-network reimbursement. It is your responsibility to determine if any pre-authorizations are required, and what ongoing communication is required by your insurance company to receive the reimbursement allowed by your individual plan. When inquiring about insurance reimbursement, please let your insurance provider know services you are receiving. If you have questions about this process, please let me know.

My standard rates are listed below. This fee schedule is subject to change, with two months' prior notice.

Intake Assessments	**Approx. Minutes**	**Fee**
Concise	60	$575

Medical Evaluation and Management (E&M)	**Approx. Minutes**	**Fee**
Standard Session	30	$220

Each session has designated time limits, as indicated in the current Clinician's Fee Schedule. In addition to fees for medical services, Dr. Woods also may charge for various cost such as the following types of services: telephone calls, time spent reviewing documents, communicating to other clinicians, preparing treatment plans/letters/reports on your behalf, and other costs incurred on behalf of the patient.

Longer calls are considered treatment sessions and are billed at the in-office rates above.

Payment is due in full at the conclusion of each session.

Payment is accepted in the form of cash, check or credit card.

Treatment Records

You may see your records upon request, and once per year may obtain without charge a printed copy of your entire record and a free summary of non-routine disclosure(s).

The *Statement of Privacy Practices* provides additional information about the maintenance of your records.

Grievance Procedures and Complaints

Please let me know if you have questions or concerns. Other sources of information and/or advocacy include your health insurance plan or behavioral health benefit manager (if applicable) as well as the Maryland Board of Physicians. If your concern involves privacy practices, you may also file a complaint with the U.S. Department of Health and Human Services.

Refill Policy

Medication refills should be initially sent to your pharmacy. If your pharmacy cannot fulfill this request, please call the office between 8:00 a.m. and 3:00 p.m. weekdays and these requests will be processed within 72 business hours of the business day the request is made. Request after 3:00 p.m. will be recorded on the following business day.

When requesting a refill, please provide:

Your name
Name of medication
Dosage
Pharmacy name and number
Date of your next appointment

Prescriptions may only be called in for patients who are current patients and who maintain their regularly scheduled appointment. For your safety, medication refills will not be called in over the weekend except in emergencies.

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Summary of Privacy Practices

Collecting and Storing Your Protected Health Information

We will only request information needed to provide quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. We save information in paper and/or electronic form.

With your authorization, we may obtain information about you from other treating clinicians, hospitals, laboratories, etc.

Protecting Your Protected Health Information

Regardless of the source, we protect your personal information to the full extent of the law.

Paper records are kept locked in our offices. Electronic records are maintained securely either on our local computers or on a centrally located computer server accessed through an encrypted Internet connection. The computers containing our practice's medical records require passwords for access.

Disclosing Any of Your Protected Health Information

You may choose to authorize us to obtain information about you from other clinicians or to share information about you with them. You also might authorize us to speak with other people you identify. The authorization form will permit you to be specific in what you would (and would not) like us to obtain and/or share.

Your insurance carrier may require documentation of your treatment in order to pay a claim. If we are accepting payment directly from your insurance provider, we will require this authorization from you as a condition of your enrollment in the practice. If you are submitting claims yourself, you may wait to provide authorization on an as-needed basis if you wish.

We will share information only as authorized by you, with exceptions only in the following situations. We will make every effort to notify you in advance if we must make any of these disclosures.

1. **Risk of Self-Harm:** If your doctor believes that you are at high risk of harming yourself s/he may arrange emergency care for you.
2. **Risk of Harm to Others:** If you express a plan to hurt another person your doctor may alert them.
3. **Mistreatment of Others:** If your doctor learns that you are abusing a child, vulnerable adult, or developmentally disabled person s/he may alert someone who is in a position to intervene.
4. **Settlement of Arrears:** If your account is in arrears and direct attempts to obtain payment have been unsuccessful, we may share a narrow subset of your personal information (e.g. your contact information and balance due) with a collection agency.

5. **Court Order:** If we receive a lawful subpoena for your information, we may need to honor it if we are unable to negotiate an alternative arrangement.

Your Rights

You have the right to review and obtain copies of all information we have on file about you and your treatment with us. We will usually provide copies free of charge, but may charge a modest amount for large requests. You also have the right to request a list of instances in which we have disclosed your protected information for uses other than stated above.

If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We will inform you if we make any changes to these policies. Please let us know if you have any questions about them.

We are required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving it.

The right to withdraw

You have the right to discharge Stacy Woods, M.D at any time and for any reason. Stacy Woods, M.D PC has the right to withdraw from treating the patient when and a permitted or required by medical ethics and state law.

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Patient Enrollment

Please take a few minutes to review the *Summary of Privacy Practices* and *Service Agreement*. Feel free to ask any questions you may have about them. They are for you to keep. Please sign below to indicate receipt of the above

Receipt of *Summary of Privacy Practices*

I have received a copy of the *Summary of Privacy Practices*.

Patient Name: ______________________________

Patient Signature: ______________________________ **Date:** ____________________

If the above is a parent or guardian of the patient, please fill in the items below:

Name: ______________________________ Relationship to Patient: ____________________

Receipt of the *Service Agreement*

I have received a copy of the Stacy B. Woods, M.D PC *service agreement* for Dr. Woods. I understand and agree to abide by them and consent to treatment. I understand and agree to abide by the cancellations and missed appointments policy.

Patient Signature: ______________________________ **Date:** ____________________

If the above is a parent or guardian of the patient, please fill in the items below:

Name: ______________________________ Relationship to Patient: ____________________

Email Communication

While it is often easy and expedient to communicate by email rather than by phone, please be advised that indirect contact that uses internet services on your phone or computer such as text messages or email are not considered confidential and may be recovered by other parties. You may lose your right to confidentiality by communicating in this manner with me, and it is advised that the confidential material conveyed in such a manner be limited.

____
Email address

____
Signature regarding approval of receiving emails or texts knowing the limits of confidentiality

Patient Information

Date_______________

Name: ____ DOB: ____________________

Sexual Orientation & Gender Identity

Sex assigned at birth (check one)

☐ Male. ☐ Female ☐ Choose not to disclose

What is your current gender identity (check one)

☐ Male ☐ Female. ☐ Transgender Male/Trans Man/Female-to-Male (FTM)

☐ Transgender Female/Trans Woman/Male-to-Female MTF)

☐ Genderqueer, neither exclusively male nor female

☐ Additional gender category, please specify: __________________

☐ Choose not to disclose

Name you would like us to use:________________________________

What are your pronouns? (e.g., he/him, she/her, they/them)________________________________

General Information

Street Address: ____

City, State, ZIP: ____

Primary Tel #: ______________________ ☐ H ☐ W ☐ Mobile ☐ OK to leave message

Alt Tel #: ______________________ ☐ H ☐ W ☐ Mobile ☐ OK to leave message

E-mail address (optional): ______________________

Medical and Referral Information

Primary Medical Care Provider: ______________________

Preferred Pharmacy: ______________________

Pharmacy Phone Number (if you know it): ______________________

Referral Source (if applicable): ______________________

Emergency Contact

Whom may we contact in the event of an emergency? ______________________

Relationship to you: ______________________

Best Number to Call: ______________ Secondary Number: ______________

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Medical Checklist

Name: ______________________________ Height: ________ Weight: ________

1. Current medical problems/physical complaints: ____

____

2. Previous medical conditions, surgeries, or injuries: ____

____

3. Have you ever had a significant head injury? A seizure? Loss of consciousness? If so, describe:

____

4. How much caffeine do you consume each day? ☐ None ☐ Coffee _____ cups per day

☐ Tea___ cups/day ☐ Energy drinks ___ per day ☐ Soda ____ per day, _____ oz each

Do you use alertness pills? ☐ No ☐ Yes Do you use caffeine after 4PM? ☐ No ☐ Yes

5. Do you use tobacco/nicotine-containing products? If so, describe: ________________________________

6. Do you drink alcohol? If so, describe: ____

7. Do you use recreational/street drugs? If so, describe: ____________________

____

8. Are you allergic to any medications? ☐ No ☐ Yes (Please provide details below.)

Medication causing allergic reaction	Type of reaction

9. What medications are you **currently** taking for psychiatric or general medical conditions? Please include herbal, homeopathic, and over-the-counter products.

Name of Medication	Dose & Frequency	Results – including Side Effects, if any	Prescriber

10. What medications have you **previously** taken for psychiatric conditions[1]?

Name of Medication	Dose & frequency	Results – including side effects, if any	Month or Year Taken

11. Past Psychiatric History - History of Hospitalizations/Suicide Attempts-

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Stacy B. Woods, M.D PC

AUTHORIZATION FOR RELEASE OF
PATIENT INFORMATION OR RECORDS

I hereby authorize:

Stacy Woods, MD
3206 Tower Oaks Blvd., Suite 400
Rockville, MD 20852
240-283-1163
301-421-1002 Fax

To disclose and receive information pertaining to the treatment of:

Patient Name (print): ____DOB:_____________

To the following individual: ____

Address and phone number: ____

Information shall be released for the purpose of psychiatric consultation or other
(Specify) _____________________

This authorization is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon.

This authorization will remain in effect until _____________________________ and will be reauthorization annually as needed.

Signature of Patient: ____ Date: ___________