LINKS Pediatric and Adolescent Behavioral Health

Caroline Kabel-Kotler, DO, FAAP

6900 E Belleview Ave

Suite 300

Greenwood Village , CO 80111

(720) 772-0130

Patient Name: ______________________ Date of Birth: ______ Age: ____ Gender: _______

Address: ____

Cell Phone Number: __________________ Other Phone Number: ____________________

Email: ________________________ May we send email/text reminders? YES __ NO __

Parent(s)/Guardian(s) - [*preferred contact]

*Name: ____________________________	Name: ______________________________
Cell Number: ________________________	Cell Number: _________________________
Email: ______________________________	Email: ______________________________
Address: ____________________________	Address: ____________________________
____________________________________	____________________________________

Preferred Pharmacy - Name, Address and Phone: ______________________________

____

Primary Care Physician - Name, Address and Phone: ___________________________

____

How did you hear about us? ____

____

Consent to Disclose Personal Health Information:

May we leave a health related voicemail message and/or text on ANY of the phone numbers you have provided to us? YES ____ NO ____

List with whom we may discuss your health, medical care, appointments, prescription information, etc., and their relationship to you.

____

Office Information and Policies

<u>Office Hours/Scheduling</u>: Monday - Friday, by appointment only.

We know your time is valuable and prioritize this in our scheduling process. To make an appointment, please call and speak directly with Dr. Kotler to ensure that your child will be scheduled for an appropropriate amount of time.

<u>Late Arrivals/Missed Appointments</u>:
If you arrive more than 10 minutes late for your appointment, you may be asked to reschedule.

If you are unable to keep your appointment, we request that you provide us with 24 hours notice of cancellation, so that we may offer that time to another patient.

If you miss your appointment without providing the requested 24 hours notice, you will be charged, as noted on our fee schedule. These fees are solely your responsibility and must be paid in full before the next appointment is scheduled. Patients who miss two or more appointments may be dismissed from the practice.

<u>Financial/Insurance Information</u>: Dr. Kotler does not contract with any insurance plans. *Payment is due at the beginning of each visit.* We are able to accept cash, checks, Google Pay, Apple Pay, and debit/credit cards. There will be a $35 fee for any returned checks. We will provide you with a receipt that contains the proper billing codes to submit to insurance for reimbursement. Reimbursement policies vary; you are responsible for understanding the agreement between you and your insurance company.

If your family is experiencing financial hardship, please speak with Dr. Kotler directly. She will work with you to the best of her ability to ensure that she may continue to provide care for your child.

If your child is currently - or at any time in the future becomes - covered by Medicaid, it is your responsibility to let us know immediately. We are unable to accept new Medicaid patients, but will continue to work with our current patients to provide ongoing care.

We understand that families and child custody issues can be complicated. The adult who brings the child for the appointment is responsible for all payments at the time of service. If you have a court order that indicates that a different person is responsible for medical bills, that agreement is between the documented parties. We will not be responsible for separate collections.

Communication to your primary care pediatrician is provided at no cost. Personal copies of medical records are provided for a fee, as set by Colorado law.

Communication Policies: Clear, complete and respectful communication is vital for a positive physician-patient relationship. Dr. Kotler is available to her patients around the clock by text and phone and trusts that they use this access appropriately. While face-to-face visits are the gold standard of care, she also offers telehealth options for when face-to-face visits may not be possible. We offer secure, private communication options.

We also understand that some families prefer the convenience of standard texts and emails. These are not considered secure or compliant with the Health Insurance Portability and Accountability Act (HIPAA).

If you choose to use these unsecured forms of communication, please indicate by initialling here that you understand the risk that by using standard text and email options your private information may become public and that you accept responsibility for that choice. Yes: ______ No: ______

Initials: _____

As part of a comprehensive behavioral health practice, patients may receive prescriptions for medications - some of which may be psychotropic and/or controlled substances. Both the health benefits and the health risks of these medications will be discussed with patients prior to starting these medications. Due to the risk of interactions, in order to make the best possible medical decisions, Dr. Kotler needs to have correct and complete information regarding any other medications, supplements and legal or illegal substances you may be using. It is her responsibility to ask, but ***it is your responsibility to provide honest and complete answers***.

Telemedicine: While convenient and sometimes necessary, telemedicine is not an ideal replacement for office visits. It can be difficult to evaluate patients remotely. Doctors get a better sense of patients' conditions through a face-to-face, in person, evaluation. When possible, this is our preferred mode of care.

<u>Release of Medical Records</u>: I hereby authorize the release of my medical records, (including mental/behavioral health), with no limitations to any physician listed below:

From & To: *LINKS PABH - ℅ Dr. Kotler, 2352 Meadows Blvd., Ste 300, Castle Rock, CO 80109*
From & To: ____
List any limitations: ____

<u>General Consent for Care and Treatment Consent for a Minor</u>: You have the right, as a patient/parent/guardian, to be informed about your [child's] condition and the recommended evaluation and treatment to be used so that you may make the decision whether or not to undergo any suggested evaluation or treatment after knowing the risks and benefits involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended and you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with Dr. Kotler, including the purpose, potential risks and benefits of any tests or treatments ordered for you. If you have any concerns regarding Dr. Kotler's recommendations, we encourage you to ask questions.

I voluntarily request Dr. Kotler and/or her designees, as deemed necessary, to perform any reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient/Parent/Guardian Signature: ______________________________ Date: ____________
If patient is less than 18 years of age - indicate relationship of signee: __________________

A minor who is **fifteen years of age or older** may consent to receive mental health services to be rendered by a facility or a professional person. Colo. Rev. Stat. § 27-65-103(2).

Consent for Use and Disclosure of Health Information (HIPPA Consent)

Effective Date of this Notice: 3/1/2020
Privacy official: Dr. Caroline Kabel-Kotler - (720) 772-0130

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to: ***Get a copy of your paper or electronic medical record.*** You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. ***Ask us to correct your medical record.*** You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days. ***Request confidential communications.*** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. ***Ask us to limit what we use or share.*** You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. ***Get an electronic or paper copy of your medical record. Get a list of those with whom we've shared information. Get a copy of this privacy notice.*** You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly. ***Choose someone to act for you.*** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action. ***File a complaint if you feel your rights are violated.*** You can complain if you feel we have violated your rights by contacting us directly. You may also choose to file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints. We will not retaliate against you for filing a complaint.

You have some choices in the way that we use and share information as we: Tell family and friends about your condition and provide mental health care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

We typically use or share your health information in the following ways: To treat you. To share with other professionals who are treating you. To run our organization. To bill for your services. We never market or sell personal information. We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

We can share health information about you for certain situations such as: Preventing disease. Helping with product recalls. Reporting adverse reactions to medications. Reporting suspected abuse, neglect, or domestic violence. Preventing or reducing a serious threat to anyone's health or safety. We can use or share your information for health research. We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. We can share health information with a coroner, medical examiner, or funeral director when an individual dies. We can use or share health information about you: For workers' compensation claims. For law enforcement purposes or with a law enforcement official. With health oversight agencies for activities authorized by law. For special government functions such as military, national security, and presidential protective services. To respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities: We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request and on our website.

LINKS Pediatric and Adolescent Behavioral Health

Fee Schedule

Please note: Included in the following fee structure, at no additional cost for established patients, are any letter requests regarding your child's care, telephone consultations with your child's primary care physician, and after hours text/telephone access. Telehealth visits are provided at the same cost as on-site visits.

Office Visits:

Medication Recheck Visit
$185.00
(Missed Visit Fee - $160.00)

Behavioral Follow-Up Visit
(Including Developmental/Individualized Education Plan Report Review)
$415.00
(Missed Visit Fee - $315.00)

New Consult
$775.00
(Missed Visit Fee - $575.00)

Genetic Testing Report Review
$500.00
(Missed Visit Fee - $400.00)

Educational Advocacy:

Face-to-Face Visit in Preparation for Individualized Education Plan/School Meetings
$315.00/hour

Attendance at Individualized Education Plan/School Meeting
$675.00
This fee includes travel of up to 40 minutes each way.
There will be an added fee for travel >40 minutes from the office.

Telemedicine Patient Consent Form

Patient Name: ______________________________ Date of Birth: __________

Purpose: The purpose of this form is to obtain your consent to participate in a telemedicine consultation/visit with Dr. Kotler of LINKS Pediatric and Adolescent Behavioral Health. If you have any questions, please call to speak with Dr. Kotler.

Nature of Telemedicine Consult: During the telemedicine consultation, details of your current and past medical, behavioral, family, and educational history, examinations, tests, and/or imaging may be discussed with you, your family and friends, your educational team, and others whom you may choose to include through the use of interactive video, audio, and telecommunication technology; a physical examination of you may take place; video, audio, and/or photo recordings may be taken of you during the service(s).

Benefits: Telemedicine is convenient, it saves you time and travel and allows increased access. You also don't have to leave your home or leave work to receive care.

Risks: It can be difficult for doctors to evaluate patients remotely. Doctors get a better sense of patients' conditions in person, through a physical evaluation. So, there is a real likelihood of misunderstanding and/or misdiagnosis with telemedicine. Despite our reasonable and appropriate efforts to eliminate any confidentiality risks associated with the telemedicine consultation, as with any other digital interaction, there is still a risk of hacking or other information confidentiality breach.

Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultation. Please note, not all telecommunications are recorded and stored.

Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and Colorado state law apply to information disclosed during this telemedicine consultation.

Rights: You may withhold or withdraw consent to the telemedicine consultation/visit at any time without affecting your right to future care or treatment.

Disputes: You agree that any dispute arriving from the telemedicine consult will be resolved in Colorado, and that Colorado law shall apply to all disputes.

You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. All your questions have been answered and you understand the written information provided above.

I agree to participate in a telemedicine consultation/visit with Dr. Kotler of LINKS Pediatric and Adolescent Behavioral Health.

Patient/Parent/Guardian Signature: ______________________________ Date: ________
If patient is less than 18 years of age - indicate relationship of signee: ______________________