Treatment Consent

James R. Rodio, MD
29425 Chagrin Boulevard, Suite 301
Pepper Pike, Ohio 44122
(216) 292-0610

The office psychiatric services are provided in a professional manner with a caring approach. The treatment is individualized to include psychotherapy and/or prescribed medications, depending on the clinical situation. I will refer patients to another agency if treatment dictates. Your signature on this form acknowledges consent for treatment.

Appointments

Services are provided by appointment only and can be arranged with the secretary (216) 292-0610. Appointments start and end in a timely fashion, so the patient is advised to arrive 15 minutes early. Full session fee is charged for late arrivals, and the next patient will expect to start in a timely fashion. Please contact the office 24 hours in advance for cancellations and to avoid full session fee; any cancelled appointment time will then be used for other patients pursuing treatment.

Professional Service Fees

Treatment fees are discussed at the beginning of treatment and may be adjusted yearly in January. Phone calls or text messages requiring more than 5 minutes will be billed at a prorated rate and will include time for required research, so the patient is encouraged to address important issues in session. Additional paperwork for Disability, FMLA, letters. etc., will similarly be billed the prorated rate. Any possible legal appearance will be discussed to determine appropriateness and also is billed at a prorated rate. Bank checks returned for insufficient funds will be billed at $50.

Insurance/Managed Care

This practice does not accept private or government insurance; in other words, it is "out of network" from insurance. As a private practice, the content, course and duration of treatment will be determined by clinical need, without interference from insurance dictates. This approach allows the treatment to be tailored individually to each patient's specific needs and affords privacy from electronic databases. Clinical time is used for treatment and not requirements imposed by insurance.

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Payment/Billing

Payment in full is required at the time of service. Payment by credit card on file allows for automatic processing by the next business day. The office can be notified if the patient prefers to pay by cash or check (see above notice for insufficient funds).

For patients wishing to do so, the office can file a courtesy insurance claim for services if the billing specialist is notified. For the portion of services not covered or "out of network," the insurance company will directly bill the patient and these charges are entirely the responsibility of the patient. In order to avoid this process, some patients will choose to establish services without insurance involvement.

Failure to pay fees can result in termination of treatment; in this case a referral will be made to an alternate treatment provider with 30 day medication coverage in transition.

Medication Prescriptions/Refills

In-session prescriptions will provide enough medications to last until the next appointment. In the event of appointment cancellation, please call the office 5 working days in advance for requested refills. Faxed pharmacy requests are not accepted by this office. An office prescription line can be accessed from the main office line; messages should include name, date of birth, medication, dose, pharmacy with phone number and any other relevant information. Some prescriptions can be sent electronically, some need to be written manually - at the discretion of the prescriber. Any insurance-dictated prior authorization may result in a delay of medication fill.

Treatment Privacy

Health information remains confidential and protected from outside sources, except in rare circumstances:

In emergencies, relevant clinical information (including labs) is shared with other physicians or treatment providers in order to provide necessary patient care.

Imminent risk of harm to self or others will be reported to appropriate agencies or individuals.

Child or disabled adult neglect/abuse will be reported to the Department of Children and Families.

Crimes committed on premises are reported to the appropriate police agency.

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In the event of a lawsuit, relevant information may be released for legal proceedings.

If the government has a legal right to general health oversight information, the office may be required to release limited information in some circumstances.

Treatment information is not released to family members or friends (unless the patient signs a specific release of information). The office may listen (without identifying that a patient is in treatment) to messages from community members about patients.

Release of Information

If a patient is changing treatment providers or residency, the office will have the patient sign a release of information. Records can be sent to another provider or agency. If relevant, phone consultation from the office can describe treatment history.

Treatment Consent

Please sign to give consent for necessary medical treatment and to confirm that you have read, understood and agree to comply with this treatment agreement.

Signature _____ Date _____

If further questions arise, please address them with the office staff or in treatment session.

James R. Rodio, MD

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Health History Form

James R. Rodio, MD
29425 Chagrin Boulevard, Suite 301
Pepper Pike, Ohio 44122
(216) 292-0610

Name:_____ Date:_____

Reason for seeking treatment:

_____
_____
_____
_____
_____

Current Medications:

_____
_____
_____
_____
_____

Hospitalizations, Detoxes or Rehabs:

_____
_____
_____
_____
_____

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Past Medications / Reason for Stopping:

Other Medical Conditions:

Surgeries / Injuries / Allergies:

Primary Care Physician:_____ Telephone #:_____

Family History of Illness:

Other Information;

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As per treatment agreement, a credit card on file will be used to render services. I authorize JAMES R. RODIO, MD, LLC to charge the credit card automatically after each provided service (including unexcused appointment No Shows) as outlined in the signed Treatment Consent.

CARDHOLDER INFORMATION

Name of Patient: _____

Cardholder Name: _____

Address: _____

CARD INFORMATION

Credit Card: _____--_____--_____--_____

Expiration: _____

Security Code: _____

_____Am Ex _____MC _____Visa _____Health Savings Card _____Debit/Other

_____ _____
Cardholder's Authorized Signature Date

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