Anna R. Flynn, M.D. Service Corporation

Anna Flynn, M.D.

Board Certified Adult, Child & Adolescent Psychiatrist

-- OFFICE POLICY --

We are pleased to have this opportunity to work with you. We regard health care as a collaboration between patient, doctor, and the other members of your treatment team – including family members/significant others, primary care physician and therapist. Thank you for helping us to work with you, to create the quality care to which we are committed.

1. **Payment** in full is required at the time of service.

2. **In an emergency**, Dr. Flynn is available by cellular phone, at **847-212-1909**. Please call immediately regarding any urgent medical/psychiatric issues, including significant side-effects of medication and any significant changes in behavior (including agitation, threats of suicide or violence, or new onset of hallucinations). However, if your situation becomes physically unsafe – whether due to a medical emergency such as unexplained or excessive bleeding, loss of consciousness, possible overdose, etc., or due to dangerous psychiatric symptoms — please call "**911**" directly so that those trained personnel can provide immediate professional emergency services. If you are unable to reach Dr. Flynn immediately in the case of an emergency, please proceed directly to your nearest emergency room.

3. **Telephone calls between appointments** are reserved for urgent medical/psychiatric issues. Other issues, including lab results, should be addressed at your next scheduled appointment unless you and your doctor have made arrangements otherwise. A service fee will be charged for calls on non-urgent issues. This fee is currently set as a pro-rated fee based upon Dr. Flynn's hourly charge of $450.00. These fees are not covered by most health insurance contracts, and are the patient's personal responsibility.

4. **If you are unable to keep your scheduled appointment**, Dr. Flynn needs a one day (24 hours) notice. Since we usually have a "waiting list" of patients wishing a sooner appointment; reasonable prior notice of cancellations permits us to better accommodate everyone's needs. Except in cases of family/medical emergency, appointments canceled with less than one day notification will be charged a pro-rated service fee based upon Dr. Flynn's hourly charge. "No Shows" will be charged the same. These fees are not covered by health insurance contracts, and are the patient's personal responsibility. Note that repeated "No Shows" (more than 3 in a calendar year) will result in the termination of our treatment relationship. Scheduling and, when necessary, timely rescheduling, remain the patient or guardian's privilege and responsibility.

5. **If you arrive more than 10 minutes late for your scheduled appointment,** your appointment may be cancelled to avoid inconveniencing other patients. If your appointment is cancelled or shortened due to a late arrival, you will be charged the full service fee.

6. **Prescriptions** will be refilled at each appointment, following re-evaluation of your condition and medical needs, and we will provide you with at least sufficient medication and refills to extend until the next scheduled appointment. In the event of an emergency (*e.g.*, while out of town or on weekends) small amounts of medication may be available directly from a pharmacist.

7. **Between-session telephone refills** not occasioned by emergency will be subject to a $25 fee (which is not reimbursable by your health plan coverage). Refills will be phoned in within 5 business days of the telephone request.

8. Ritalin, Focalin, Metadate, Daytrana, Concerta (methylphenidate), and Dexedrine and Adderall (amphetamine) prescriptions are required by Illinois law to be handwritten (telephone prescriptions and refills are not permitted), and expire 7 days following the prescription date. It is therefore imperative that patients fill these prescriptions promptly. Should the prescription expire, the expired prescription must be returned for our records, and a re-written prescription may then be obtained. The fee for such refills is $25 (which also is not reimbursable by your health plan coverage – again, this fee is waived in cases of rescheduling due to emergency).

9. **For review of past medical records and for report preparation**, your charge will be pro-rated in five minute increments at Dr. Flynn's hourly charge of $450.00. These fees are not be covered by health insurance contracts, and are the patient's personal responsibility. (This does not apply to legal cases, which are billed at a separate rate.)

Anna R. Flynn, M.D.
(847) 212-1909 Fax: (312) 275-7884
181 Waukegan Road Suite 105 Northfield, IL 60093

10. We recognize that our patients (and their guardians) have the right to refuse treatment, which includes the discontinuation of medications or psychotherapy. However, in order to responsibly and effectively serve you as your physicians, **we need to know of medication changes** (including discontinuation!) **in advance**. If communicating with your psychiatrist in advance regarding alteration/discontinuation of prescribed medications is for any reason unfeasible (for instance, the emergence of a side effect or medication reaction), please alert your doctor as soon as possible. If this policy is in any way objectionable to you, please discuss these objections with your psychiatrist before consenting to the prescription of any medication.

11. **Your psychotherapy** is also an important component of your medical treatment, and, again, Dr. Flynn needs to be aware of any significant interruptions in therapy, so that she may continue to responsibly and effectively serve you as your physician. If you are considering discontinuing psychotherapy against your therapist's advice, please contact your psychiatrist before finalizing such termination.

12. **Cases will automatically be closed 120 days after the date of your last visit unless an appointment is scheduled shortly thereafter.** Subsequent appointments will be made at the next available opening for new patients. There may be a waiting list. Referrals to other treatment providers will be provided upon request.

13. **Notice of Privacy Policies:** Confidentiality is your right, and our duty. The privacy of all records pertaining to your treatment will be maintained securely by us. Records will be kept for a minimum of seven (7) years, will be used only for appropriate treatment purposes, and will be released only with your specific written consent or authorization, as provided for by Illinois and Federal law. You have the right to review your records (including the record of disclosures made). We charge a reasonable fee for copying records requested by you. If at any time you feel your privacy has been violated, you have the right to file a grievance with us and/or with the Secretary of the U.S. Department of Health and Human Services. Please note, however, that the law requires the release of otherwise confidential information when the provider reasonably believes disclosure is necessary to protect against harm to yourself or others, or when there is suspicion of child or elder abuse, and when records are demanded by Court Order.

14. Your active participation is essential to Dr. Flynn's ability to provide quality services to you while keeping fee increases to a minimum. **Please assist her** by taking responsibility for this participation in your medical care. Ways that you can help include:

    - Provide advance **written consent for release of information** to those with whom you wish us to work in your treatment – primary care physicians, school personnel, spouse/family members, therapists and other consultants.
    - Assist us to expedite receipt of **lab values** from clinical laboratories and your other doctors' offices, and submit **questionnaires** as recommended to your child's school.

15. If treatment is sought for a minor child of divorced or separated parents (or for any person whose **guardianship** has been settled by Order of Court), our office *must* have on file a copy of the divorce decree or other Court Order specifying the terms of custody, visitation and guardianship, particularly regarding guardianship for healthcare. We must receive consent in advance for our services (both evaluation and treatment) from a party legally authorized to give consent for healthcare services. Payments of fees to our office will be the sole responsibility of the parent or guardian signing here as "responsible person" notwithstanding any court order or decree assigning financial responsibility for healthcare to any other party. (Reimbursement from any other such party – e.g., co-parent – to the payee for payments made to us must be arranged directly by the signing "responsible person;" our office cannot bill such third parties.)

Thank you for understanding our Office Policy. If you have any questions, please do not hesitate to ask us– we are here to assist you. Please sign below indicating you have read and understand this policy and agree to abide by it.

Signature _____ **Date** _____
Of Patient, if over age 18

Signature _____ **Date** _____
Of Guardian and/or financially responsible person, if applicable

Anna R. Flynn, M.D.
(847) 212-1909 Fax: (312) 275-7884
181 Waukegan Road Suite 105 Northfield, IL 60093