Cohen & Associates
Effective Solutions. Compassionate Care.

NEW PATIENT FORMS

PRIVATE AGREEMENT

This Agreement is between Patient and Cohen and Associates (the "Practice"), Rebecca S. Cohen, M.D. ("Dr. Cohen"), Robin M. Bixler, D.O. ("Dr. Bixler"), Teri Callender, LCSW, PAC ("Teri Callender"), and Mindy Sherbet, LCSW ("Mindy Sherbet") whose principal place of business is 1217 South East Avenue, Suite 209, Sarasota, FL, 34239.

Fee

Patient accepts full responsibility for payment of the hourly Fee and any other services provided by Rebecca S Cohen, MD, Robin Bixler, DO and Teri Callender LCSW, PA-C, Mindy Sherbet, LCSW, or the Practice. Patient shall pay fees in full at the time of service.

The fee is not covered by insurance

Neither the Practice, Dr Cohen, Dr. Bixler, Teri Callender, nor Mindy Sherbet, will file or accept an insurance claim as payment of the Fee. Patient understands that Patient's insurance carrier may not reimburse Patient for any of the services received from the Practice, Dr. Cohen, Dr. Bixler, Teri Callender, or Mindy Sherbet, LCSW, pursuant to this Agreement.

Representations of patient

Dr. Cohen, Teri Callender, Dr. Bixler and/or Mindy Sherbet, has informed Patient that we have opted out of the Medicare program. Patient is aware that services provided pursuant to this Agreement will not be covered or reimbursed by Medicare. Patient, or Patient's legal representative, as the case may be, has the capacity to enter into this Agreement on behalf of Patient.

Patient is not currently experiencing an emergency medical condition requiring immediate treatment.

Term and termination of the agreement

The term of this Agreement is one year from the date hereof. This Agreement will automatically renew at the end of one year, unless Patient provides notice of cancellation to the Practice prior to the date of renewal. Any party to this Agreement may terminate this agreement by providing written notice to the other party at least thirty (30) days before the termination is desired. The death of Patient shall also terminate this Agreement. Upon termination of this Agreement, or failure to pay any Fee by the due date, Dr. Cohen, Dr. Bixler, Teri Callender, or Mindy Sherbet will no longer be Patient's physician or therapist and Patient shall be responsible for obtaining an alternate physician or therapist.

NOTICE TO MEDICARE RECIPIENTS

Medicare requires Rebecca S Cohen, MD, Robin Bixler, DO, Teri Callender LCSW, PA-C or Mindy Sherbet, LCSW ("your psychiatric provider" or "therapist"), to inform Patient of the following information:

• **Your psychiatric provider has opted out of the Medicare program**.

• **Medicare will not pay for any items or services provided by your provider or the practice.** Because your psychiatric provider has opted out of Medicare, Medicare will not pay for items or services which would have otherwise been paid for as covered items or services. Patient cannot receive reimbursement from Medicare for any expense Patient incurs in the Practice office and your provider will not file any claim with Medicare on Patient's behalf.

• **Medicare limitations do not apply** to the amounts that your psychiatric provider or the Practice staff may charge for any item or service.

• **Medigap plans do not pay for services provided by your psychiatric provider or the practice.** Any supplemental insurance plans Patient has may not pay or reimburse Patient for items and services provided by your provider or the Practice. Patient agrees to work directly with Patient's supplemental insurance company to determine if Patient's plan will reimburse Patient for your provider's services.

• **Your psychiatric provider has no intention of rejoining the Medicare program.**

• **Patient is responsible for payment of the hourly Fee and the Fee is not reimbursable by Medicare.**

• **Agrees that patient may not legally submit a claim to Medicare for payment of the items or services provided by your psychiatric provider or the practice, nor will patient request that your provider or the practice submit a claim to Medicare**.

There are multiple physicians in the Sarasota area who have not opted out of Medicare. Patient may obtain services covered by Medicare from those physicians. In the event Patient desires a referral to a Medicare participating physician, your provider will provide Patient with a referral. In the event Patient seeks services from a Medicare participating physician, that physician must provide Patient any Medicare covered services under the Medicare program and cannot require Patient to pay any additional fee above the co-pay and deductible and cannot compel Patient to enter into any private contract for Medicare services.

• Your psychiatric provider is not excluded from Medicare under sections 1128, 1156, or 1892 or any other section of the Social Security Act.

EMAIL AND TEXT MESSAGE COMMUNICATION

Patient acknowledges that e-mail and text messaging are not secure mediums for sending and receiving potentially sensitive personal health care information. Although communications between Patient, Dr. Bixler, Dr. Cohen, Teri Callender, and Mindy Sherbet are subject to confidentiality requirements, the Practice cannot assure the confidentiality or protection of e-mail and text message communications. E-mail and text messages sent to the Practice, Dr. Bixler, Dr.

Cohen, Teri Callender, and Mindy Sherbet, may be accessed by individuals who are not directly involved in Patient's care. In addition, Patient acknowledges that e-mail and text messages are not a good medium for urgent or time sensitive communications. Time sensitive communications should be handled by direct telephone contact or in person. E-mail communications shall become a part of the Patient's medical record.

MISCELLANEOUS PROVISIONS

This Agreement is personal in nature and may not be assigned by the Patient without the consent of Dr. Bixler, Dr. Cohen, Teri Callender, Mindy Sherbet or the Practice. This Agreement constitutes the only agreement between the parties and supersedes any and all prior agreements between them with regard to the Patient. In the event of any change in the law that has an adverse effect on the Practice's ability to provide the services hereunder in the format set forth in this Agreement, the parties will work together in good faith to modify the terms of this Agreement to comply with the change in the law so that the intent of this Agreement is carried out as close to its original manner as practical. This Agreement shall be governed by Florida law, and venue shall be proper only in a court seated for or in Sarasota County, Florida. There are no thirdparty beneficiaries to this Agreement.

SIGNATURES

The Parties hereto agree to the terms and conditions set forth above.

Patient Signature: _____

Patient Name (Printed): _____

Date of Birth: _____

Date: _____

E-SIGNED DR. COHEN, DR. BIXLER, TERI CALLENDER, MINDY SHERBET AND THE PRACTICE

Rebecca S. Cohen, M.D., Robin Bixler, D.O, Teri Callender, LCSW, PA-C, Mindy Sherbet, LCSW, Individually and as President of the Practice

HIPAA NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability and Accountability act of 1996 "HIPAA" is a federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act gives you, the patient, the right to understand and control how your personal health information (PHI) is used. HIPAA provides penalties for covered entities that misuse personal health information.

We will not disclose your health information to others unless you tell us to do so, or unless the law authorizes or requires us to do so.

We may use and disclose your medical records for each of the following purposes: treatment, payment and healthcare operations.

Treatment: means providing, coordinating, or managing healthcare and related services by one or more healthcare providers may also need to provide information to others providing your care. For example, we may share your medical information with other physicians and healthcare providers, hospitals, laboratories to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you. An example of this is coordinating care with a primary care doctor who referred you to the practice.

Payment: payment means such activities as obtaining reimbursement for services, confirming coverage, billing and collections activities and utilization review. Since you are paying directly for your care and we do not contract directly with insurance companies your health information will not be released to the insurance company unless you request a superbill (invoice) from us and provide the information directly to the insurance company yourself.

Healthcare operations: this includes business aspects of running a practice, such as conducting quality assessments and improving activities and customer service. This could also include accounting, legal, and risk management services. We may also call you by your first name in the waiting room when your provider is ready to see you. We may contact you by phone or in writing to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The practice may also be required or permitted to disclose PHI for law enforcement and other legitimate reasons. When disclosure is required, only information that is essential is revealed.

We may use and disclose your protected health information without your authorization as follows: To Report suspected child or elder abuse to public authorities. If there is reasonable cause
to believe the client imposes imminent harm to self or another individual, If the treating provider is compelled to give information pursuant to a valid court order or subpoena. To comply with Worker's Compensation laws if you make a worker's compensation claim. For public health and safety purposes as allowed or required by law to prevent or reduce a serious immediate threat to the health or safety of a person or the public

Food and Drug Administration: we may disclose health information about you to the FDA or to an entity regulated by the FDA, in order to report an adverse event or a defect related to a drug or medical device.

For health and safety oversight activities: for example, we may share health information with the Department of Health. To coroners and medical examiners, we may disclose health information to a coroner or medical examiner to identify a deceased person and determine the cause of death.

The following use and disclosures of PHI will only be made pursuant to us receiving written authorization from you: most uses and disclosure of psychotherapy notes uses and disclosure of your PHI for marketing purposes, including subsidized treatment and healthcare operations disclosures that constitute a sale of PHI under HIPAA you may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken action relying on your prior authorization.

You have the following rights with respect to your PHI. You have the right to: receive, read, and ask questions about this notice. Ask to restrict certain uses and disclosures. You must deliver this request in writing and we will try to comply with any request made. Request and receive from us a paper copy of the most current notice of privacy practices for protected health information, obtain a copy of medical records or have it sent to another individual or organization (we will usually have you sign a release of information form when records are being sent).

Request amendments: At any time if you believe the PHI we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended. At your request, we will give you a list of disclosures of your health information. Cancel prior authorizations to use or disclose health information by giving us a written revocation.

This notice is effective as of June 16, 2020 and it is our intention to abide by the terms of the notice of privacy practices and HIPAA regulations currently in effect. We reserve the right to change the terms of our notice of privacy practices and to make the new notice provision effective for all PHI that we maintain. We will notify you and you may request a written copy of the revised notice of privacy practices. If you believe that your privacy rights have been violated you have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services office of civil rights.

I am a patient of Rebecca S Cohen, MD, Robin Bixler, DO, Or Teri Callender LCSW, PA-C, Mindy Sherbet, LCSW and I hereby acknowledge receipt of the Notice of Privacy Practices.

Patient Signature: _____

Date: _____

MISSED APPOINTMENT AND CANCELLATION POLICY

For the convenience of all patients, we respectfully request that you cancel your scheduled appointment a minimum of 48 hours in advance. Receiving cancellation information in advance allows us to schedule and to serve other patients. We recognize that unforeseen circumstances can arise and sometimes appointments cannot be canceled in advance. With that in mind, a single missed appointment will be forgiven as a courtesy. However, after one missed appointment or late cancellation you will be charged the full appointment for any other appointment that is not canceled within the 48-hour time frame. This fee will be your responsibility to pay before your next visit. Thank you for your understanding in this matter.

By signing below, I agree that I have read and understand the above policy on missed appointments.

Patient Signature: _____

Date: _____

INFORMED CONSENT FOR TELEPSYCHIATRY SERVICES

Telepsychiatry involves the use of two-way videoconferencing to enable you to participate in treatment sessions with your psychiatrist from a remote location, such as your home or other private location. Treatment sessions are similar to in-person sessions, in that you and your psychiatrist can communicate in real time while seeing each other over live video. While telepsychiatry is similar to in-person care, there are differences and some associated limitations. Here are the expected benefits, as well as risks, to consider before proceeding with telepsychiatry.

Expected Benefits:

• Minimized exposure to infectious diseases, including COVID-19

• Improved access to medical care by enabling you to remain at a remote site, such as your home, while still receiving regular medical care

• Greater consistency in scheduling

• Greater efficiency in diagnosis and treatment

Possible Risks:

• Reduced ability to perform certain aspects of a physical examination or evaluation

• Insufficient information (e.g., poor resolution of images or audio) to allow for appropriate medical decision making by your psychiatrist

• Technical problems or failures interrupting or delaying treatment sessions

• Failure of security protections resulting in a breach of protected health

Telepsychiatry Platform:

Telemedicine appointments will be conducted through the HIPAA-compliant, encrypted platform doxy.me.

You will need to use a camera-enabled computer, tablet, or smartphone during the session. Please advise your psychiatrist of an alternate telephone number or other contact method, in the event technical problems interrupt your treatment session. It is important for your psychiatrist to know where you are physically located during your treatment session, in case an emergency arises. Please try to establish a consistent location for you to participate in telepsychiatry sessions.

In-Person Care:

You have the right to discontinue telepsychiatry sessions and proceed through in-person care, if you feel it would be more beneficial to you. Your psychiatrist may determine that due to certain circumstances, telepsychiatry is no longer appropriate and resume in-person treatment sessions. In an emergency, your psychiatrist may advise you to proceed to an emergency room or other direct care facility for further evaluation and treatment. Please proceed to other direct care facilities for further evaluation and treatment. Please designate at least one emergency contact person and the closest emergency room to your location.

Privacy and Confidentiality

It is important for you to be located in a quiet, private space that is free of distractions (including cell phones or other devices) during sessions. It is important to use a secure internet connection during treatment sessions, rather than public or free Wi-Fi. Confidentiality still applies for telepsychiatry services; treatment sessions will not be recorded without the express permission of all participants, including you and your psychiatrist. I understand that my personal information obtained and location at the time of services will be provided to local and/or state authorities in the event that I could be a danger to myself or others.

By signing this form, I indicate the following:

1. I have read and understand the expected benefits and risks associated with telepsychiatry, discussed this with my psychiatrist, and any questions have been answered to my satisfaction.

2. I understand that I have the right to withhold or withdraw my consent to the use of telepsychiatry in the course of my care at any time.

3. I understand the laws that protect privacy and the confidentiality of medical information also apply to telehealth; that appropriate measures will be taken to secure transmitted information and maximize privacy and confidentiality.

4. I hereby give my informed consent for the use of telepsychiatry in my medical care.

Patient Signature: _____

Date: _____

CONTRACT FOR TREATMENT WITH CONTROLLED SUBSTANCES

The purpose of this contract is to protect your treatment with controlled substances/ medications and to protect your prescriber's ability to prescribe these medications for you.

Your Physician may be prescribing medications that have been classified by the Drug Enforcement Agency (DEA) as having the potential of producing dependence and addiction. State and federal laws prohibit the transfer of these medications to any other person. Furthermore, the controlled medication should be kept in the bottle dispensed by the Pharmacist.

All of your medication should be filled with the same pharmacy. No telephone or fax refills will be allowed for controlled substances. If the prescribed medications are stolen or lost, they will not be replaced. It is important to keep all controlled medications out of reach of children.

You must be seen for an appointment to get a new prescription and no early refills or changes to your medications will be allowed without an appointment.

Any misuse or abuse of the medications will result in termination of services.

The risk and potential benefits for treatment with controlled medications have been fully explained to me, and are understood, including but not limited to physical dependency, addiction, withdrawal, and potential risk of over dosage. I am aware that attempts to obtain a controlled medication under false pretense is illegal. I understand that tampering with the prescription is a felony. I will not alter my prescription at any time for any reason, as it is unlawful to do so.

My signature denotes that I fully understand this contract and am willing to abide by these rules. I understand that failure to comply with this contract will result with my being discharged from care with a 30 day notice to find another health provider.

Patient Signature: _____

Date: _____

CREDIT CARD AUTHORIZATION

Robin Bixler D.O., Teri Callender LCSW, PA-C, Rebecca Cohen M.D., Mindy Sherbet, LCSW are authorized to charge the credit card on file for the fee for each session.

Patient Signature: _____

Date: _____

EMAIL, TEXT MESSAGES AND VOICEMAIL CONSENT FORM

Patients in our practice may be contacted via email, voicemail, and text messaging to remind you of an appointment, to obtain feedback on your experience, and to provide general health reminders/information.

I consent to receive text messages and/or voicemail from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails, voicemail and text messages will apply to all future appointment reminders/feedback/health information unless I request **a** change in writing.

I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information to the Cell Phone number given to the practice.

I authorize to receive emails for appointment reminders and general health reminders/feedback/information in the Patient Portal.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Signature: _____

Date: _____