JGC Consultations, LLC
Justin Capote MD

Adult & Consultation-Liaison Psychiatry

105 Grove Street, Suite 14-2, Montclair, NJ 07042

Phone: 973-671-8535 Fax: 973-695-3633

Email: jgc@justincapotemd.com Web: www.justincapotemd.com

PATIENT INFORMATION

Name: _____

E-mail: _____ Phone:_____ DOB:_____

Mailing Address: _____

Policies and Procedures

General Practice Information:

Thank you for choosing JGC Consultations, LLC. The following information was prepared so that you may have a clear understanding of my policies concerning fees, insurance, and confidentiality. JGC Consultations, LLC is a part-time, individually-run, private psychiatric practice. *Please be aware that there is no front desk staff or after-hours coverage.* To communicate with me, please email jgc@justincapotemd.com or call or text 973-671-8535 to leave a message. During scheduled absences, contact information for a covering physician will be provided in my away message. Please note that covering physicians are not partnered with this practice and may use their discretion when it comes to refilling prescriptions for controlled substances. *In the event of an emergency, call 911 or go to your nearest emergency room for help. If you are ever in crisis, you can contact the National Suicide Prevention Lifeline by dialing 988 and remaining on the line.*

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Payment:

This is a fee-for-service practice that does not accept Medicaid or Medicare. *If you are a Medicare or Medicaid beneficiary, please read and complete the **Physician-Patient Private Contract** (page 5). *Please refer to my website for the most current fee schedule.* Fees vary depending on appointment length. Fees are re-evaluated annually and increases will be announced in advance of changes taking place. Available visit types include office visits, video visits, and phone sessions. A receipt for services will be provided upon request. A receipt can aid patients in submitting claims for reimbursement to their insurance company. Please note that submitting a claim to your insurance company does not ensure full or partial reimbursement. Reimbursement for out-of-network services is dependent on the type of insurance plan. Payment in the form of cash, check, or credit/debit card is accepted and is due in full at the time of your appointment. _____ **Please initial** that you have read, understand, and agree to the above described terms. **If you have New Jersey Aetna and/or were referred through Alma, please read and initial below.*

*NJ Aetna patients ONLY

It is crucial that you provide Headway with your most up-to-date insurance information to ensure that they can check your eligibility, payment responsibility, and manage proper claim submission to NJ Aetna on our behalf. If you are unsure of your insurance details, please contact your insurance carrier directly before meeting with me. You should complete an eligibility check on your Headway account prior to scheduling with me. Claims for our appointments will be submitted to your insurance carrier and you will be responsible to Headway for any uncovered costs and copays. You will not be responsible to me for any payments unless you fail to make your payments to Headway at any time. To ensure that this does not happen, please enroll in AutoPay on your Headway account prior to meeting with me. If a payment method is not stored on your Headway account, and if payments to Headway are missed at any time, your treatment with me will be suspended and potentially terminated. _____ **Please initial** that you have read, understand, and agree to the above described terms and that you are familiar with your Headway and/or Aetna membership details, privacy policy, arbitration policy, and any other relevant policies which are not summarized here.

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Appointment Cancellations & Rescheduling:

To avoid cancellation fees, please provide at least 24 hours notice for appointment cancellations. *Missed appointments and late cancellations will be billed in full.* Appointment reminders are sent electronically two days prior to scheduled appointments. Appointment reminders contain the video link for video visits. Please ensure that all emails from JGC Consultations, LLC are directed to your inbox. _____ **Please initial** that you have read, understand, and agree to the above described appointment cancellations & rescheduling agreement.

Confidentiality:

Any protected health information that you disclose to me during treatment, or any other confidential information that I obtain while attending to you professionally, shall be held in confidence unless you permit me to disclose such information or where I am required to disclose such information by law, as described below. By initialing, you are agreeing to the disclosure of confidential information to other physicians and therapists familiar with your case where it is clinically necessary or appropriate to do so. For example, if another physician or therapist referred you to me for evaluation, I may communicate with that provider about your condition and previous treatment. _____ **Please initial** that you have read, understand, and agree to the above described HIPAA/Confidentiality agreement.

Forensic Matters:

The law requires that confidential information be disclosed in certain cases. The following are examples: 1.) If it is assessed that a patient is an imminent danger to themselves or others, and if that person has access to firearms, appropriate others and/or law enforcement will be notified. Please be aware that law enforcement can confiscate the firearms of such identified individuals; 2.) If there is reason to suspect that child or elder abuse has occurred, that suspicion will be reported to the proper authorities; 3.) In a legal proceeding, the Judge may order disclosure of information they feel would be necessary for the proper administration of justice. In the event that JGC Consultations, LLC is subpoenaed to appear in a court action involving the care that was delivered to you, you may be charged for court appearances and will be expected to pay for those services. _____ **Please initial** that you have read, understand, and agree to the above described forensic matters agreement.

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CONSENT TO TREATMENT

I, _____, agree to receive treatment from JGC Consultations, LLC. This includes the use of telehealth, such as meeting remotely and communicating electronically. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent to treatment may be communicated verbally or in writing. By signing and dating this document I am acknowledging that I have read, understand, and agree to all policies and procedures of JGC Consultations, LLC.

_____ _____

Signature of legally responsible party **Date**

EMERGENCY CONTACT INFORMATION (optional):

Name: _____ Relationship: _____

Phone and/or Email: _____

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Physician-Patient Private Contract

(Patient-Physician Agreement for claim non-submission)

***For Medicare/Medicaid Beneficiaries ONLY**

You, the patient, and JGC Consultations, LLC, have entered into a private agreement outside of Medicare. Medicare REQUIRES your agreement to the following term MEDICARE HAS SPECIFIED before we can proceed. This Agreement protects Medicare from payment responsibility for service you receive directly from JGC Consultations. If requested by Medicare, this Agreement will be provided to resolve any misunderstanding and clarify our intent.

This Agreement must be signed in order for JGC Consultations to treat you as a patient. Please review the following and sign this Agreement to confirm your acceptance of the terms of this Agreement:

The undersigned patient/Medicare beneficiary (or the Medicare beneficiary's legal representative, either is referred to as "Medicare Beneficiary") is signing this Private Contract to evidence his or her understanding and agreement regarding payment for any services to be provided by JGC Consultations, LLC ("Physician"). The Physician's practice entity is known as JGC Consultations, LLC (also referred to as Physician). Physician hereby certifies that Physician is not and has not been excluded from participation in the Medicare Program under section 1128 or other applicable sections of the Social Security Act.

By executing this Private Contract, Medicare Beneficiary acknowledges and agrees as follows with respect to all items or services provided by Physician to Medicare beneficiary:

● That Medicare Beneficiary will not submit a claim, or request for Physician to submit claim, for payment under Medicare, even if such items or services would otherwise be covered under Medicare.

● That Medicare Beneficiary understands that NO reimbursement for payment in full at the time of service, in accordance with Physician's current fee schedule, whether Medicare Beneficiary is reimbursed through private insurance or otherwise, for payment for all such items or services.

● Physician is not limited by Medicare in the amount that he or she may charge Medicare Beneficiary for the items or services provided, and that Medicare Beneficiary will pay Physician's charges in full at the time of service.

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Physician-Patient Private Contract continued

(Patient-Physician Agreement for claim non-submission)

***For Medicare Beneficiaries ONLY**

● That Medigap plans to not make payment, and other Medicare supplemental insurance plans may choose not to make payment, for items or services furnished by Physician.

● That Medicare Beneficiary has the right to have the items or services sought from Physician to be provided by other physicians or practitioners whose items or services would be covered by Medicare.

● That Medicare Beneficiary is not in an emergency or urgent health care institution.

● That Medicare Beneficiary agrees to reimburse Physician for any costs, collection fees, and reasonable attorneys fees that result from violation of this Agreement by Medicare Beneficiary.

● That Medicare Beneficiary acknowledges a copy of this Agreement has been provided to Medicare Beneficiary.

● That Medicare Beneficiary signs this Private Contract voluntarily and upon full understanding of its terms.

Patient/Beneficiary (or legal representative)

Printed Name:

_____

Patient Beneficiary (or legal representative)

Signature: **Date:**

_____ _____

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CONTROLLED SUBSTANCE AGREEMENT

In the event that my treatment requires the use of controlled substance(s), I adhere to the following: 1.) I am reading and making this agreement while in full possession of my faculties and not under the influence of any substances that might impair my judgment. 2.) I will not obtain any controlled medication from another medical provider without informing this practice of the circumstances involved. This includes pain pills, muscle relaxers, anti-anxiety, or stimulant medications. 3.) I will notify my medical provider of any new health concerns I have even if not obviously related to my treatment. 4.) I will not be involved in the sale, transport, or sharing of any controlled substance or medication. 5.) I will safeguard my medication from loss or theft. I will carry only the amount of medication I need, in the prescription bottle, for the time away from home, leaving the rest in a safe place. 6.) I will not take larger or more frequent doses than what is written on the prescription bottle. 7.) I will not ask for early refills. 9.) If I am female, I understand that if I become pregnant, or if I suspect that I am pregnant, I will notify my provider immediately. 10.) I understand that my provider regularly checks the prescription monitoring program and evidence of obtaining controlled substances from another provider or pharmacy may result in termination of my treatment with JGC Consultations. I have read this document and agree to the guidelines. If I had any difficulty understanding the content, I have asked for clarification. If my prescription(s) is/are not helping to improve my daily life, I will report this to my provider. I understand that if this agreement is not followed, JGC Consultations may choose to terminate my treatment.

_____

Printed name of legally responsible party

_____ _____

Signature of legally responsible party **Date**

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Stimulant Patient Information and Agreement Form

Stimulant medications are most often prescribed for attention deficit/hyperactivity disorder but may also be used for daytime somnolence, cognitive enhancement after a traumatic brain injury, or as a short term adjunct to antidepressant therapy. There are generally three types of stimulant medications available, methylphenidate products (e.g. Ritalin), mixed amphetamine salt products (e.g. Adderall), and dextroamphetamine products. Some of the brand names of these products include Ritalin, Concerta, Focalin, Adderall, Dexedrine, and Vyvanse. All stimulants have the same potential side effects. The two most common side effects are decreased appetite and insomnia. Stimulants may also cause stomach aches and headaches. In some cases, motor or vocal tics can occur when you take a stimulant. If you have tics before you start stimulant medication, your tics may worsen. Tics related to stimulant medication will generally resolve or return to their baseline after the stimulant is stopped. Stimulants can also increase blood pressure and heart rate by a small amount, although this is very rarely clinically significant. Stimulants have the potential for abuse, addiction, and withdrawal and are not to be taken daily or for extended periods of time. Stimulant medication does not replace non-pharmacologic interventions such as organization, exercise, and sleep hygiene. Behavioral changes are an integral part of treatment success. Stimulants are highly controlled by the FDA and are carefully monitored. For these reasons, lost or stolen prescriptions may not be refilled or replaced. By signing this form you acknowledge the above and consent to the terms of treatment.

_____

Printed name of legally responsible party

_____ _____

Signature of legally responsible party **Date**

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Sedative Patient Information and Agreement Form

Sedatives are most often prescribed for the short term management of anxiety or insomnia. Commonly used medications in this class include benzodiazepines such as diazepam (Valium), lorazepam (Ativan), clonazepam (Klonopin), and alprazolam (Xanax). Please be aware that benzodiazepine-like prescription sleep aids such as zolpidem (Ambien) carry a similar risk profile. All benzodiazepines have the same potential side effects. Some of the most commonly reported side effects are drowsiness, forgetfulness, impaired concentration, difficulty multitasking, slowed reaction time, incoordination, slurred speech, and symptoms of emotional disinhibition like social inappropriateness or quickness to anger or tears. It is not recommended that you drive or operate heavy machinery after taking a benzodiazepine because of the effect these medications have on attention and responsiveness. Benzodiazepines have the potential for abuse, addiction, and withdrawal and are not to be taken daily or for extended periods of time. The withdrawal from benzodiazepines is very similar to the withdrawal from alcohol and can potentially be dangerous. Benzodiazepines are never to be combined with alcohol. Sedative medication does not replace non-pharmacologic interventions such as diaphragmatic breathing, exercise, and sleep hygiene. Behavioral changes are an integral part of treatment success. Benzodiazepines are highly controlled by the FDA and are carefully monitored. For these reasons, lost or stolen prescriptions may not be refilled or replaced. Non-benzodiazepine sedatives such as antihistamines (e.g. hydroxyzine) may be offered as a first-line option. By signing this form you acknowledge the above and consent to the terms of treatment.

_____

Printed name of legally responsible party

_____ _____

Signature of legally responsible party **Date**

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Consent to Release Protected Health Information

Please complete this release of information form in order to grant me permission to discuss your case with individuals identified by you for any reason that we have discussed. Please let me know separately if you would like any specific information withheld from such discussions. Please only include ONE party per form. Fill out separate authorization forms for each additional party. Parties may include your previous psychiatrist or psychotherapist, primary medical doctor, a family member, caseworker, attorney, etc.

I, _____, authorize Dr. Justin Capote to discuss and share confidential information about my treatment with the party listed below, and vice versa. This confidential information includes, but is not limited to, my history of psychotherapy and psychotropic medication use, my medical and family histories, my history of drug and alcohol use, my legal and financial status, the results of diagnostic testing, my clinical progress and planned or possible treatment interventions, and any other information deemed important by Dr. Capote to assist with my treatment and/or other personal or business matters requested including, but not limited to, insurance reimbursement, legal action, regulatory action, marital conflict, or child custody. Please include the full name and contact information for the party identified below.

Name of party being authorized: _____

Preferred method of contact: _____

I acknowledge that this consent can be revoked by me in writing at any time, and that I can do so for any reason except to the extent that: 1. This authorization is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; 2. Disclosure has already occurred; 3. Any pending action that relies on this disclosure has already been taken and/or is in progress.

Patient Signature: _____ Date: _____