General Practice Policies

Please read the Terms and Conditions carefully to ensure you understand Hope and Wellness Psychiatry/Integrative Wellness and Health policies regarding website use, services, privacy practices, fees, etc. Your signature serves as confirmation that you understand and agree with the policies below. A copy of policies is available by request. Hope and Wellness Psychiatry/Integrative Wellness and Health reserve the right to modify or replace these Terms at any time. You will be provided at least 30 days' notice prior to any new terms taking effect.

Consultation and Treatment

An initial appointment at Hope and Wellness Psychiatry/Integrative Wellness and Health is a consultation to determine whether your needs as a patient fit with the services that our practices offer. It does not automatically result in the establishment of a patient-doctor relationship, nor does it guarantee treatment. It is important that you provide accurate information during your consultation to ensure that the treatment being offered by Hope and Wellness Psychiatry/Integrative Wellness and Health is the most appropriate.

Services provided by Hope and Wellness Psychiatry/Integrative Wellness and Health are geared toward low-acuity cases for patients age 4 and older. If a higher level of care is needed, such as residential treatment or Intensive Outpatient Programs, information on mental health services in Tucson and the surrounding area will be provided with appropriate recommendations.

There is no guarantee that services rendered at Hope and Wellness Psychiatry/Integrative Wellness and Health will result in successful treatment of symptoms. Payment is due for services provided without expressed guarantee of results for those services.

All treatment at Hope and Wellness Psychiatry/Integrative Wellness and Health is voluntary. You may discontinue care at any time. Note that requests for refills will be limited to no more than 30 days after expressing intent to discontinue care.

Your active participation and compliance with the treatment plan, including, but not limited to, consistent and proper use of medication, completion of labs, abstaining from illicit substances, or finishing therapy "homework," are expected as part of your treatment plan. You are responsible for tracking your refills and contacting Dr. Dube if you experience any problems related to your medication or therapy.

For minors, permission is required by your parent(s) or guardian(s). Parents/Guardians are expected to actively participate in their child's care.

Your care may be terminated by Dr. Dube due to lack of treatment compliance or other reasons outlined in these policies.

Disability paperwork, custody evaluations, or letters supporting Emotional Support Animals are not provided by Hope and Wellness Psychiatry/Integrative Wellness and Health. Medications may not be refilled at the time of the consultation.

Payment Policy

Services are self-pay and Hope and Wellness Psychiatry/Integrative Wellness and Health are considered “out of network.” NO INSURANCES ARE ACCEPTED.

Payment is due prior to booking your appointment. You can receive a refund if your appointment is cancelled up to 48 hours prior to your scheduled appointment. Cancellation within 48 hours results in forfeiture of payment.

A fee of $50 will be assessed for returned checks or insufficient funds for credit cards.

Hope and Wellness Psychiatry/Integrative Wellness and Health accepts cash, check, Visa, Mastercard, Discover, or American Express only.

Hope and Wellness Psychiatry/Integrative Wellness and Health will not provide any patient information to a third party nor will it be used for any reason other than patient care coordination.

Hope and Wellness Psychiatry/Integrative Wellness and Health contains links to a third-party payment system to process your payment and has no control over, and assumes no responsibility for, the content, privacy policies, or practices of the third-party website or services. You further acknowledge and agree that Hope and Wellness Psychiatry/Integrative Wellness and Health shall not be responsible or liable, directly or indirectly, for any damage or loss caused or alleged to be caused by or in connection with use of or reliance on any such content, goods, or services available on or through any such website or services.

Recommendations for lab testing, prescriptions, supplements, or psychological testing may incur additional fees.

Fee Schedule for Hope and Wellness Psychiatry/Integrative Wellness and Health, as of June 1, 2020:

Consultation/Evaluation:
Adult – up to 90 minutes: $400 Consultation
Child & Adolescent – up to 90 minutes: $450
Follow Up Appointments:
Adult – up to 60 minutes: $285
Adult – up to 30 minutes: $185
Child & Adolescent – up to 60 minutes: $300
Child & Adolescent – up to 30 minutes: $200
Medication only appt up to 15 minutes for stable and established patients: $75
Phone calls, letters, forms, prescription renewals, prior authorizations requiring more than 5 minutes are billed at the rate of $300/hour

Office Policy

The office is located at 4806 E Camp Lowell Drive, Tucson, AZ 85712. The office phone number is 520-329- 8976. The office fax number is 520-505-4827. The website for Hope and Wellness Psychiatry is www.hopeandwellnesspsychiatry.com and for Integrative Wellness and Health is www.IWAHpsychiatry.com.

Phone calls, secure messaging, and messages sent through the website will be returned within 72 business hours.

Established patients will be asked to voluntarily register for the Patient Portal provided by Hope and Wellness Psychiatry/Integrative Wellness and Health via third party Electronic Health Record (EHR) at no additional cost. This will allow communication via secure messaging with Dr. Dube, as well as access to portions of your health record.

Hope and Wellness Psychiatry/Integrative Wellness and Health will make every effort to not reschedule within 24 hours of your appointment, unless there is an emergency or extenuating circumstance.

Your appointment time is scheduled for you only. Hope and Wellness Psychiatry/Integrative Wellness and Health does not double book appointments. As such, it is imperative that you arrive on time for your appointment as your appointment time will end no matter what time you arrive. For example, if you are scheduled for a 60-minute follow up appointment from 9am to 10am and arrive at 9:30am, your appointment will still end at 10am. You will not receive a refund for the shorter appointment.

Cancelling within 48 hours or missing your appointment will result in forfeiture of the appointment fee.

Missing your consultation appointment will result in forfeiture of the appointment fee and you will not be allowed to reschedule.

Three missed follow-up appointments, lack of treatment compliance, failure to pay for services, disagreement in treatment goals, use of illicit substance, misuse of medications, increased acuity,

violation of Hope and Wellness Psychiatry's/Integrative Wellness and Health's policies, or other concerns will result in termination of care. You may be prescribed refills up to 30 days or a tapered dose of controlled substances in the event of a termination of care.

Patients prescribed controlled medications (DEA Schedule II, III, IV, V, etc.) are subject to random lab testing. High dose benzodiazepines or stimulants are not typical practices of Hope and Wellness Psychiatry/Integrative Wellness and Health. Lost or stolen prescriptions will not be refilled without a police report.

Hope and Wellness Psychiatry/Integrative Wellness and Health participates in the Controlled Substances Prescription Monitoring Program as required by the state of Arizona. You may be subject for review, especially if controlled substances are being considered as part of your treatment plan.

Hope and Wellness Psychiatry/Integrative Wellness and Health does not offer crisis management, after-hours access, emergency medical or mental health services, or primary care. Call 911 or go to the nearest Emergency Department if you are having suicidal or homicidal thoughts, have an emergency, or you are in crisis. You may also call 1-800-273-TALK or text 741741.

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 READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a Federal program that requires 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. HIPAA 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.

As required by HIPAA, Hope and Wellness Psychiatry/Integrative Wellness and Health prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operation.

Treatment means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this is if you are referred to a specialist by a primary care doctor.

Payment means such activities as obtaining reimbursement for services, billing or collections, and utilization review. An example of this would include you sending a bill to your insurance company for reimbursement.

Health Care Operations include the business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be case management and care coordination.

The practice may also be required or permitted to disclose your PHI for law enforcement or other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment options.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:
Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations, and other uses and disclosures not described in this notice.

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 actions relying on your prior authorization,

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.

- The right to inspect and copy your PHI.

- The right to request amendments to your PHI. This request may be declined, but you will receive the rationale in writing within 60 days.

- The right to receive an accounting of disclosures of your PHI.

- The right to obtain a paper copy of this notice from us upon request.

- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed,

- If you have paid for services “out of pocket,” in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of March 1, 2019, 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 Practice and to make the new notice provision effective for all PHI that we maintain. We will post, and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

4806 E Camp Lowell Drive Tucson, AZ 85712 Phone: 520-329-8976 Fax: 520-505-4827

Authorization to Release/Receive Confidential Information

I authorize to:

Sutapa Dube, MD

at the above address

Patient Name: _____ Physician Name: _____
Patient DOB: _____

- Receive my medical/therapy records from the following healthcare professionals:

(name, address) _____
_____

(name, address) _____
_____

- Release my medical records to the following healthcare professionals:

(name, address) _____
_____

(name, address) _____
_____

I am requesting this information is for the following purposes:

_____

_____

_____

_____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will expire five (5) years from the date of signature unless I withdraw my consent. I understand that the records released may contain information pertaining to psychiatric treatment, including substance use treatment. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits recipients of these records from making any further disclosures to third parties without the express written consent of the patient.

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Patient Signature: _____ Date: _____

Credit Card Authorization Form

I authorize Hope and Wellness Psychiatry/Integrative Wellness and Health to run my debit/credit card to reserve an appointment time. I understand that the payment will be processed through www.stripe.com, a third-party payment system and Hope and Wellness Psychiatry//Integrative Wellness and Health does not have my payment information on file.

Patient Signature: _____ Date: _____

Printed Name: _____