

POLICIES AND PROCEDURES

These are the office policies and procedures that are likely the most important to your care here. I have tried to make these as simple and straightforward as possible, but please feel free to ask for clarification as needed.

Privacy and release of information:

In order to maintain the safety and trust necessary for good psychiatric care, I uphold the highest standards of patient confidentiality. Psychotherapy notes will **never** be released. There are, however, certain situations in which I must, by law, communicate your confidential information. Here is a list of those circumstances:

- I have reason to believe you are a danger to yourself or another person or persons.
- I become aware of abuse to child, elder or developmentally disabled person.
- I am under court order to release information.
- Subpoena of treatment records by an attorney. (I will not immediately release records upon receipt of a subpoena, but will do anything in my power to keep your records private. Usually a court order will be required. You have up to fourteen (14) days to obtain a protective order from the court to avoid disclosure of your records.
- If you are applying your health insurance benefits, I may be required to provide information to your health plan, including some or all of your patient chart, in order for them to approve payment. By signing the "Acknowledgement of Receipt of Office Policies and Procedures" form you consent to release that information to your health plan.
- If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment here.
- In some instances, as provided by the state law of Texas, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

Moontower Wellness, LLC does not share mobile numbers, text messaging originator opt-in data, or consent with any third parties or affiliates for marketing or promotional purposes. Mobile information may be shared only with subcontractors and service providers that support the delivery of SMS services, such as messaging platforms, telecommunications providers, or customer support vendors. This information is used solely to provide and operate the messaging service.

All other use case categories exclude text messaging originator opt-in data and consent. This information will not be shared with any third parties.

COLE WEATHERBY, D.O.
Moontower Mental Wellness, PLLC
1154 Lydia St., Suite 110
Austin, TX 78702

Phone: 512-522-7708 Fax: 512-233-0824

Emergency and after-hours contact:

Messages left on voicemail are checked several times each day, except on holidays and weekends. I am my only employee, so sometimes I will not be able to respond as rapidly as a larger office. I make every attempt to respond to calls within one business day.

If you need more rapid attention or are in crisis, call 911 immediately or report to the nearest emergency room or psychiatric hospital. There is a psychiatric emergency department located in the emergency room at Dell Seton Hospital. Here are some helpful emergency numbers:

Austin Lakes Hospital Admissions: 512-544-5253
Travis County Crisis Hotline: 512-472-HELP (4357)
National Crisis Hotline: 1-800-SUICIDE (784-2433)
Poison Control: 1-800-222-1222

Patient Records:

An electronic record is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to entities you designate. Under certain circumstances where seeing the record may put a patient or other person at risk, I may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record.

Use of insurance benefits and patient responsibility for fees:

Only your health insurance plan can describe your benefits to you or verify provider eligibility. I will help you obtain this information from your health insurance plan, but you must contact the health insurance plan directly for verification. *If charges are denied by a health insurance plan they become entirely your responsibility*, even if you had understood from your health insurance plan that the charges would be paid by them.

Payment and Fees:

Payment for charges not covered by your health insurance plan (including co-payments and deductibles) is due in full at the time services are provided unless prior arrangements have been made.

Fees: Initial office visit/consultation- \$450
50 minute psychotherapy- \$300
25 minute psychotherapy/medication follow-up- \$200
Extended phone call (>10mins)- \$45 per 10 minutes

Stimulant prescription refills between visits- \$15 each

Above fees are subject to change, however, any changes will be discussed with you. Fees for other services are by arrangement. These fees updated 12/19/2023.

Cash and check are the preferred forms of payment. Please make checks payable to "Moontower Wellness".

Late cancellations and missed appointments:

Failure to keep your scheduled appointment will result in a charge unless you cancel at least twenty-four (24) hours prior to the appointment time. If you have had 0-1 missed appointments in the past 12 months, the fee is half of the self-pay fee for the type of visit missed. If there have been 2 or more in the previous 12 months, the full self-pay fee for the length of appointment you had scheduled will be charged. Please note that insurance plans do not pay for missed appointments, so these charges will be entirely your responsibility. I also reserve the right to end our doctor/patient relationship in the case of repeated missed appointments that are interfering with my ability to uphold standards of care.

Unpaid bills:

Bills are due 30 days from receipt of statement or other notification. If you are unable to pay your bill because of some financial hardship, please discuss this with me to see if we can arrive at a mutually agreeable payment plan that allows you to continue treatment. Seriously delinquent accounts may be referred to a collections agency and may lead me to end our relationship as doctor and patient. Should it become necessary to file suit in this context, you will be responsible for any legal charges incurred. Statements will typically be sent to your e-mail address. If you have an aggressive spam filter, please check your spam folder periodically and make the billing company Kareo or Square a trusted sender.

Grievances and complaints:

If you have concerns about administrative/business matters or about your treatment, please discuss them with me. In addition, or instead, the following avenues are available to you:

1. Contact your health insurance plan or behavioral health benefit manager.
2. If you feel the problem is serious and/or you have not reached resolution through one of the avenues above, you can file a complaint with the Texas Medical Board, Attn: Investigations, 333 Guadalupe, Tower 3, Suite 610, PO Box 2018, MC-263, Austin, TX 78768-2018 or call 1-800-201-9353.
3. You may also file complaints regarding privacy practices with the Secretary of the U.S. Department of Health and Human Services.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF OFFICE POLICIES AND PROCEDURES

I have received a copy of Cole Weatherby, D.O.'s Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy. I have received and reviewed the Notice of Privacy Practices, as required by HIPPA standards.

Patient Signature: _____ Date: _____

Authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I, the patient or patient's legal representative, hereby grant permission to Cole Weatherby, D.O. to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that the practice of medicine is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination.

Patient Signature: _____ Date: _____

Printed Name: _____

Authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

Signature: _____ Date: _____