Policies and Procedures

If you have any questions not covered by this statement, please let us know so we can provide clarification.

The Practice: Dr. McKenna is a child, adolescent and general psychiatrist who has worked in a variety of clinical settings. After graduating in high standing from an accelerated and combined undergraduate/graduate school at the University of Missouri, Dr. McKenna completed her internship and residency at Washington University in St. Louis. After Dr. McKenna graduated from her residency in general psychiatry, she continued her education at Washington University by completing a fellowship in child & adolescent psychiatry. During her medical training, she was promoted to Chief Physician.

Dr. McKenna has been a leader within the psychiatric community. During her fellowship, she was selected to the Regional Executive Committee of the American Academy of Child & Adolescent Psychiatry. She also served as the psychiatric quality improvement chair at Washington University. Dr. McKenna looks forward to helping you and your family!

Telemedicine: Telemedicine is the practice of providing medical care via electronic communication. With recent advances in technology, telemedicine is now more popular than ever. MD SUPPORT communicates with patients through VSee, which is a HIPAA compliant video conferencing application. Telemedicine appointments are clinical visits, but instead of doing them in an office, you will be able to see the doctor from the comfort of your own home or office!

VSee can be easily downloaded onto your computer, smartphone or tablet. To register for an account on VSee.com, you simply need to 'sign up' with your name and email. At the time of your appointment, open the application and wait for the doctor's call.

In-Person Visits: Dr. McKenna does offer in-person visits in St. Petersburg for those interested. Depending on medication needs, some patients will be asked to have an initial in-person visit to ensure compliance with federal regulations regarding controlled prescriptions.

Fee for Service: The initial intake is a comprehensive diagnostic assessment where Dr. McKenna will gather important information regarding your psychiatric and medical history. She will discuss previous treatments as well as the past and current concerns. Because Dr. McKenna focuses primarily on clinical care, she sees patients on a fee-for-service basis.

If you have insurance, we have partnered with a billing company called Claimly. You can now go through our website to submit your requests for reimbursement right after your bill is paid. This means you can get your reimbursement from insurance within 1-3 business days. We can also prepare a superbill for you to send directly to your insurance provider for potential reimbursement.

Rates:

Initial Psychiatric Appointment: $450 for the entire visit which lasts up to 90 minutes.

Follow-up Visits: Based on the time requested with a rate of $420/hr. If additional time is spent outside of what is requested, you will be charged per minute based on our normal hourly rate. Scheduled appointment times can be 15, 30, 45, 60, 75 or 90 minutes.

Phone calls (outside of simple questions/scheduling etc): Cost based on normal clinical rates. For the doctor's time, this rate is $420/hour. For our staff's time, this rate is $80/hour.

Emails (outside of emails for scheduling or simple questions): Cost based on normal clinical rates. For the doctor's time, this rate is $420/hour. For our staff's time, this rate is $80/hour.

Letter/form completion: Cost based on normal clinical rates. For the doctor's time, this rate is $420/hour. For our staff's time, this rate is $80/hour.

Time on prior authorizations or insurance issues: Cost based on normal clinical rates. For the

doctor's time, this rate is $420/hour. For our staff's time, this rate is $80/hour.

Medication refills outside of scheduled appointments: $35 and up based on complexity of the script(s) and the situation. Emergency/Urgent refills requested after hours and over holidays/weekends start at $50.

Financial Agreement: Payments for all visits are due in advance of each appointment. You will be charged through your chosen form of payment, usually the business day before your appointment. You will be charge for your expected or requested appointment time. Standard visits are set for one hour. Please let us know if you would like a shorter appointment so we can adjust the schedule and charge you for this amount only. If your appointment goes beyond the scheduled time, we will charge you for the extra minutes spent based on the doctor's normal rate of $420/hr the following business day.

It is important to always keep us up to date on your payment information. If we are unable to collect payment before your appointment, your appointment will be canceled, and you will be charged a late fee that is equal to the appointment time you have scheduled (plus $25 for in-person appointments). Also keep in mind that you will not be able to schedule appointments or receive medication refills without current payment information. We do not accept insurance directly but have partnered with Claimily to help you get reimbursed quickly. If you would like a superbill to send to your insurance provider directly, please let our staff know and this can be prepared.

Cancellation and Late Fee Policy: We ask that you give us 24 business hours notice for appointment cancellations or to reschedule so that we can use the reserved time to treat other patients. To protect this time, you will be charged the cost of the visit in the event that you do not cancel 24 business hours in advance. If you cancel your appointment more than 24 business hours in advance, there is no charge. Late cancellations are based on the time allocated for the appointment. If there is confusion about the amount of time requested, you will be charged based on the time spent during the previous visit. The length of the appointment is based on time spent and begins at the start of the session. If a patient schedules an hour appointment but is 10 minutes late and then spends 55 minutes, they will be charged for 10 + 55, a total of 65 minutes. We understand that things happen, but we must charge for the time allocated for the visit as well as the time spent.

Emergencies: Call 911 or go to the nearest emergency department for all medical or psychiatric emergencies — including the risk of harm to self or others. Dr. McKenna will do her best to communicate with outside treatment facilities as able.

Clinical Questions: Feel free to email our support team at admin@md.support or Dr. McKenna at rachel@md.support.

Phone calls are answered by the support team on Monday through Friday from 9:30am until 4:30pm. If outside of those hours, please leave a message and we will get back to you by the next business day. The main office number is 813-567-5675. Urgent emails/calls after business hours will be responded to promptly.

Office Hours: Clinical visits are by appointment only Monday through Friday from 10:00 until 6:00 pm. Occasional night and weekend visits are offered at additional cost.

Medication: Refills should be requested directly from our office rather than through the pharmacy. Please give us at least three business days notice for refill requests so that you do not run out of your medication on a weekend or holiday. Please provide the following information to facilitate accurate refills: patient's full name, date of birth, medication name, dosage and directions as well as the pharmacy name, zip code and telephone number. We will notify you when your refill request has been completed.

Confidentiality and Release of Information: All information disclosed within sessions is confidential and may not be revealed to anyone outside of the practice without your written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, and/or danger of harm to self and/or to others unless protective measures are taken.

MD SUPPORT
Online Therapy and Care

Patient Name:_____
Parent/Guardian Name (if applicable):_____

Date of Birth:_____

Social Security Number: _____

Phone:

Home:_____Cell:_____
Email:_____
Address:_____
_____

Pharmacy Name: _____ Phone:_____
Address/Zip:_____
_____

Current Medication (name, dosage and frequency)
_____
_____
_____
_____

Height: _____ Weight _____

How did you hear about us?
_____

General Office Policy Consent: The patient or the patient's legal guardian hereby consents to the written policies and procedures and agrees to abide by said office policies and procedures.

_____ _____

Patient or guardian signature Date

General Medical Consent: The patient or the patient's legal guardian hereby consents to general and medical care, including but not limited to medical services, X-ray and laboratory examinations rendered to the patient by or under the general or special instructions of Dr. McKenna or the staff at MD SUPPORT, LLC.

_____ _____

Patient or guardian signature Date

CREDIT/DEBIT AUTHORIZATION

I (we) hereby authorize _____ (MD SUPPORT) to initiate entries to my (our) checking/savings accounts at the financial institution listed below, and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until MD SUPPORT is notified by me (us) in writing to cancel it in such time as to afford MD SUPPORT and my (our) financial institution a reasonable opportunity to act on it.

Name and Address of Financial Institution - Branch, City, State, & Zip:

_____

_____

Financial Institution Routing Number:_____

Checking/Savings Account Number:_____

Print Name (as it appears on the account):

_____

Address (as it appears on the account):

_____

Signature: _____

Date: _____

Or

Sign and complete this form to authorize MD SUPPORT, LLC to charge your credit card listed below for appointments for _____.

By signing this form you give us permission to charge your account per our policy rates for clinical appointments/form completion/late fees.

Please complete the information below:

I _____ authorize MD SUPPORT, LLC to charge my credit card/account indicated below per the policy rates on or after today's date. This payment is for clinical visits and associated charges as noted in the policies of the clinic which can be provided as requested.

Name on the Card:

_____

Billing Address: _____

Phone #: _____

City, State, Zip: _____

_____

Email:_____

Type of Card: _____

Card Number:

_____

CVV#:

_____

Expiration Date:

_____

SIGNATURE _____

DATE _____

I authorize the above named business to charge the credit card indicated in this authorization form according to the terms outlined above. This payment authorization is for the goods/services described above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

Consent for Use or Disclosure of Health Information

MD SUPPORT is very concerned with protecting your privacy. While the law require us to give you this disclosure, please understand that we have and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services (ie: Insurance).

We may need to use your health information within our practice for quality control or other operational purposes such as recall notices, reminder calls, and treatment news. All health and patient information disclosed to MD SUPPORT, shall remain confidential and we will ensure that all federal and state laws pertaining to confidentiality of patient health information, including HIPAA are complied with.

Your right to limit uses or disclosure:

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions other use or disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization:

You may revoke any of your authorizations at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

HIPAA Release Form

Patient Name:_____

Date of Birth:_____

Release of Information:

I authorize the release of information including diagnoses, labs, and any medical information. This information may be released to and from the staff and clinicians of MD SUPPORT along with the following people/places:

Patient Support Person: *(Since there is a telepsychiatry aspect to this practice, we ask all adults to identify one other adult who can be reached in any case of emergency to help provide care or even transportation to a hospital or emergency room if needed.)*

Name:_____

Relation to you: _____

Phone #: _____

Email: _____

Other providers that you give us permission to contact:

MD SUPPORT
Online Therapy and Care

Name of Primary Doctor:_____
Specialty:_____ Phone #:
_____ Fax #: _____

Name:_____Specialty:_____
Phone #: _____ Fax #: _____

Name:_____Specialty:_____
Phone #: _____ Fax #: _____

This release of information will remain in effect until terminated by patient or guardian in writing.

Signature of Patient or Guardian: _____

Date: _____