Ashwini Gulwadi, PLLC
101 W. Liberty, Suite 360, Ann Arbor, MI 48104
Ph: 734-984-2228 Fax: 734-984-2008
Website:gulwadimd.com

OFFICE GUIDELINES

1. The office hours are subject to change. Please review website -gulwadimd.com for details about the current office hours. The office is closed on most major holidays.
2. Dr. Gulwadi can be reached at the office phone number as listed above from Monday- Friday between 8.30 am-6pm. If she is unable to pick up the call, you are welcome to leave a voicemail with your name and phone number to call back. Calls are generally answered within 48-72 business hours. Voice mail messages left at the office on Friday afternoons or weekends will **not** be received until the following Monday at the earliest.
3. Prescription refills may be requested by phone, if needed. To request a prescription refill by phone, the patient must be actively involved in treatment and have a follow up appointment scheduled before the next refill of medications is needed. Certain medications, including stimulants and controlled substances, need close monitoring and more frequent appointments, and prescriptions for these medications cannot be mailed, called, or faxed. These prescriptions must be picked up in person. Please allow up to 48-72 business hours for the prescription to be called in. Prescriptions will only be called on Monday to Fridaay. If leaving a message, please leave the following information
   -your name, birth date, and your phone number, the medication name, the medication dosage and frequency, the pharmacy name, address, and phone number.
4. The office does not accept refill requests from pharmacies; you must contact the office yourself.
5. Dr. Gulwadi is a provider of office-based services. She does not provide emergency services, inpatient, or intensive services.
6. If you have an **emergency**, please call 9-1-1 or go to your nearest emergency room. You may also contact the Psychiatric Emergency Services at the University of Michigan Medical Center, at 734- 936-5900 or crisis line number for the county you reside in.
7. On your scheduled visits, please arrive a few minutes before your appointment. If you arrive late, your appointment will still end at the previously agreed time. If more time is needed, you will be asked to reschedule your appointment for another time. If you need to reschedule due to this reason, you will be charged for the missed appointment time.
8. If you need to cancel or reschedule an appointment, you must call 72 business hours/ 3 business days before your appointment, or you will be charged for a missed appointment.
9. Dr. Gulwadi can act as a consultant and coordinate care with your other medical and mental health providers. She cannot act as a supervisor to your therapist or other doctors.
10. Dr. Gulwadi will inform you about her vacation at least 1-3 months in advance. When Dr. Gulwadi is on vacation, coverage may be provided by another licensed psychiatrist, only for urgent issues. Instructions for contacting the covering physician will be left on the office voice mail. It will be your decision if you want to contact this physician and share information. For non-urgent issues, please contact her before or after the vacation schedule. If you have questions about this, please discuss with Dr. Gulwadi at your next appointment.
11. Rude, violent, or threatening behavior toward the business or staff associated with the business will not be tolerated. Selling of medications, forging prescriptions, and obtaining duplicate scripts of controlled substances from multiple medical professionals will not be tolerated. These actions may result in a report to legal authorities and termination from the practice.
12. Dr. Gulwadi reserves the right to terminate or transfer the care of any patient who is unable to follow the above guidelines or if a different medical setting may be deemed necessary based on the complexity of a patient/ situation. This will be informed in a written notice or termination visit at the office.
13. The patient reserves the right to terminate care at any time. It will be helpful to discuss with or inform Dr. Gulwadi either during their visit or on a phone call prior to making that decision.
14. As a part of the office center rules and regulations, no hazardous materials shall be brought into the office, office center or common areas of the building. No offensive gases, odors or liquids shall be permitted. Smoking of any form is prohibited in the office, office center and interior Common areas.
15. No weapons concealed or otherwise shall be permitted on the Property.
16. No patients or guests are allowed to bring any animals into the Office, Office center, Common areas or the Property without prior written consent from Dr. Gulwadi. If you have service animals trained to perform a task or service directly related to the patient or guest's disability, please contact Dr. Gulwadi in advance to allow for appropriate accommodation.

I have read these policies (or it was read to me), understood the contents, and agree to the terms. I understand that I may ask Ashwini Gulwadi, PLLC or Dr. Gulwadi for additional information should I need it. I agree that this authorization will remain in effect indefinitely. By signing, I am bound by these terms.

Printed name of patient or legal guardian _____

Signature_____ Date_____

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Consent for Treatment and Evaluation

I authorize Ashwini Gulwadi, PLLC to give me reasonable clinical care and treatment by today's standards. I consent to be evaluated by Dr. Gulwadi at the above office location. I understand that initial evaluation appointment does not constitute or imply a commitment to treat or otherwise provide services that may be recommended during the evaluation. It is possible that Dr. Gulwadi will recommend working with another psychiatrist, therapist, or another agency that could offer more appropriate treatment than she can provide. If this evaluation does result in a recommendation for services, which are then provided to me by Dr. Gulwadi, I agree that my continuing attendance and participation shall represent my continuing consent to being treated by her. I understand that there are no guarantees about the result of treatment with Dr. Gulwadi. I understand that the diagnostic and treatment options, risks and benefits of treatment, alternative treatment(s), and the risks of no treatment will be explained to me.

I understand that regular attendance at scheduled appointments and arriving on time for appointments will produce the maximum benefit. I agree to follow the treatment plan set by Dr. Gulwadi to the best of my abilities. If I do not comply with the treatment plan, I recognize that she may discontinue treatment with me and offer other treatment alternatives. I understand that I may discuss with Dr. Gulwadi any concerns encountered in treatment. I understand that I can withdraw consent and discontinue treatment at any time. I agree to discuss this with Dr. Gulwadi before discontinuing treatment.

Printed name of patient or legal guardian _____

Signature_____ Date_____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (to be signed at the office during your initial appointment)

Ashwini Gulwadi, PLLC has a responsibility to protect the privacy of my health care information. Notice of Privacy Practices describes how my health care information may be used and disclosed, how I can access my health care information, and whom to contact if I have questions, concerns, or complaints. I have been provided the Notice of Privacy Practices form to review on the website gulwadimd.com and as a hard copy at the office location. I can also ask Ashwini Gulwadi, PLLC for a copy of the Notice of Privacy Practices for my records, if needed. I understand that Ashwini Gulwadi, PLLC may change the Notice of Privacy Practices at any time, and I may contact Dr. Gulwadi at 734-984-2228 to obtain a current copy of the Notice of Privacy Practices. By signing below, I acknowledge that I have received a copy of this office's Notice of Privacy Practices Form.

Printed name of the patient or legal guardian: _____

Signature _____

Date_____

Witness: _____

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FINANCIAL AGREEMENT & MISSED APPOINTMENTS POLICY

1. I agree that I am responsible to pay for all psychiatric services provided by Ashwini Gulwadi, M.D, at the above listed location. Billing will not be submitted to any insurance companies or third-party payers by Dr. Gulwadi at the Ashwini Gulwadi, PLLC for services provided at the above location. (If I am a Medicare beneficiary, Medicaid or BlueCross Blue Shield, I will notify Dr. Gulwadi in advance to discuss the specifics of treatment at this or another location).
2. I understand that all fees will need to be paid in the form of credit card, cash or check payable to "Ashwini Gulwadi, PLLC" at the time of the service/appointment. Dr. Gulwadi will provide receipts for all services she provides.
3. Initial Psychiatric Evaluations and Consultations are billed as follows:
    a. Adult Psychiatric Evaluation – 40- 50 minutes session: $250
    b. Adult Psychiatric Evaluation- 75- 90 minutes session divided into 1-2 sessions: $350
    c. Extended Evaluation- 120 minutes session divided into 2-3 sessions: $400
    d. Consultation (a one-time consultation on behalf of an agency or another physician) – 90-120 minutes divided into 2-3 sessions: $450
4. Return Visits are billed as follows:
    a. Medication review + psychotherapy session -20-30 min: $140
    b. Extended Medication review and/or Psychotherapy session - 40-50 min: $180
    c. Comprehensive Medication review session/ hospital follow up visit (50-60 min): $220
5. Additional Services are billed as follows:
    a. Chart copying: $25
    b. Additional time during the return visit (beyond 60 minutes), Phone calls lasting more than 10 minutes, Preparation of patient reports for other physicians or agencies; writing letters or filling FMLA papers are billed at standard $200/hour, or the reports can be filled during the visit time.
6. I understand that the fee structure can be reviewed and adjusted by Dr. Gulwadi in the future, and that Dr. Gulwadi will inform me in advance whenever there are any expected changes in rates. (Notice will be given in form of a revised financial agreement by the office).
7. I understand that all appointments need to be cancelled 72 business hours/3 business days before the appointment date and time. I agree to pay the full cost of the scheduled session if the appointment is not cancelled at least 72 business hours in advance.

I have read these policies (or it was read to me), understood the contents, and agree to the terms. I understand that I may ask Ashwini Gulwadi, PLLC for additional information should I need it. I agree that this authorization will remain in effect indefinitely. By signing, I am bound by these terms.

Printed name of the patient or legal guardian: _____

Signature _____

Date_____

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Benefits and Fees

I understand that Ashwini Gulwadi, PLLC is a fee for service practice and that I am financially responsible for all the fees. I understand that all fees will need to be paid by me, in the form of credit card, cash or check payable to "Ashwini Gulwadi, PLLC" at the time of the service/appointment. Billing will not be submitted to any insurance companies or third-party payers by Dr. Gulwadi at the Ashwini Gulwadi, PLLC for services provided at the above location. (If I am a Medicare beneficiary, Medicaid or BlueCross Blue Shield, I will notify Dr. Gulwadi in advance to discuss the specifics of treatment at this or another location). I am aware that more information is available in the detailed financial agreement form.

Initials _____

Balances

Unpaid balances beyond 30 days, or refusal to respond to requests to pay balances, may be referred to collections and may result in negative credit report. I understand and agree that information necessary to ensure debt collection will be released to the guarantor, the collection agencies and their partners or intermediaries. I understand and agree that any collection, legal fees, court fees or other costs necessary to collect unpaid balances will be my solve responsibility.

Initials _____

Document Preparation

I understand and agree to be charged a fee for preparation of documents for third party. Fees structure is available on the financial agreement.

Initials _____

Disclosure of Confidential Matters in Legal or Administrative Proceeding

If a legal or administrative entity requests my mental health records or testimony from Ashwini Gulwadi, PLLC and I (or the agent legally acting on my behalf) wish to contest/refuse (if contesting/refusal is allowed by law), I/agent agree to pay all legal costs, court expenses, fees for physician time, and administrative expenses incurred for Ashwini Gulwadi, PLLC, regardless of the outcome of the release.

Initials _____

I have read these policies (or it was read to me), understood the contents, and agree to the terms. I understand that I may ask Ashwini Gulwadi, PLLC for additional information should I need it. I agree that this authorization will remain in effect indefinitely. By signing, I am bound by these terms. The information listed in these forms are true to the best of my knowledge at this time.

Printed name of patient or legal guardian: _____

Signature_____

Date_____

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TELEHEALTH INTAKE FORM

Personal information:
Name (first, middle, last): _____

Date of birth_____ Age: ____ Gender by birth: _____Preferred Gender: _____Preferred pronoun: _____

Preferred name if different from above listed name: _____ other names used in the past: _____

Local address: _____ City: _____State: _____ Zip:_____

Mailing/ Permanent Address: _____ City: _____ State: _____ Zip: _____

Home Phone _____ Work Phone _____Cell Phone _____

Email Address _____

Which number do you prefer to be contacted at? This number will be used for messages (circle one) Home / work / cell

Do I have permission to text you at your cell phone number? (Circle one) YES/ NO

Contact information for your emergency contact (this person will be contacted on your behalf only in case of an emergency:

Name: _____ Relationship: _____ Phone_____

Primary Care Physician Information:

Name: _____

Address _____

Office Phone_____ Office Fax_____

Therapist Information:

Name _____

Address _____

Office/Cell Phone_____ Office Fax_____

Insurance Information: (please list if it is PPO/HMO/Traditional)

Insurance Co. _____ or circle- I do NOT have insurance

Enrollee Name _____Enrollee ID_____ Issuer/Group #_____

Customer Service Phone _____Mental Health/Substance Tx Phone_____

Social and Occupational History:

If employed outside the home, describe your current job (title and main duties): _____

_____

Please list your highest level of education received: _____

Currently living with (list partner/children/family/pets with names) _____

_____

List names and location of family (parents/ siblings/ children) _____

_____

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How did you find out about my practice?

_____

Preferred Pharmacy name/ address/ Phone#:

_____

List of your allergies with reactions:

NAME OF THE MEDICATION/HERB/FOOD/OTHER	REACTION

List of all your current medications/supplements/herbs:

NAME OF ALL YOUR CURRENT MEDICATION/ SUPPLEMENTS/HERBS	DOSE	FREQUENCY	CURRENT PRESCRIBER/DOCTOR:

Have you tried any Psychiatric medication in the past: (Circle one) YES/ NO

If yes, please complete the rest of the form with details about your past psychiatric medication trials

Past Psychiatric Medication trials:

NAME OF THE MEDICATION	DOSE TIRED/HOW LONG AGO/ DURATION OF TREATMENT	REACTION/ REASON FORDISCONTINUING IT