

**Rose Ambrose, M.D.**  
10632 Little Patuxent Parkway, Suite 330  
Columbia, Maryland 21044  
(410) 884-1555

### **Information for Patients**

Welcome. I look forward to being of help to you. Below is some information about how my practice runs. Please feel free to discuss any questions you have about it.

### **Confidentiality**

Doctor-patient confidentiality is the cornerstone of psychiatric treatment. It's very important that you feel comfortable discussing what you want to without concern about others learning sensitive information. Nothing you reveal during an appointment will be disclosed without your explicit consent, except when required by law. If I believe your safety is in jeopardy I must take necessary steps to protect you. Likewise, if someone else is in danger because of your actions I have a duty to warn that person. I am also obligated to report any child abuse I become aware of. Of course, these legal exceptions are rare and unusual circumstances.

It is often helpful for me to communicate with other physicians or therapists. When a patient is on medication, I may ask for permission to communicate with a primary care doctor about basic information such as diagnosis and medications in order to enhance your continuity of care. However, in these circumstances detailed personal information revealed in session would not be revealed.

If I am seeing you for medication management and you are in therapy with another professional, I will ask for your consent to communicate with your therapist. In cases with two providers it is very important that lines of communication be clear in order to provide the best, safest care.

### **Payment**

I am not a participating provider with any insurance companies at this time. Most insurance plans offer out of network benefits—please call your insurance company to inquire about your plan, making sure to specify *out of network mental health benefits*. Also, please also inquire about *initial preauthorization* if you plan to seek reimbursement. There may be a phone number for Preauthorization for Mental or Behavioral Health on the back of your insurance card. Often preauthorization involves a telephone discussion with someone from your insurance company about your symptoms.

I receive payment directly from you at the time of service or at the end of the month for those in weekly therapy. You will be provided with a statement with includes the information you will need to submit to your insurance company for partial reimbursement if you choose to do so. *Many insurance companies require treatment plans be submitted on a regular basis—if you would like me to submit treatment plans I will be happy to do so with your permission.*

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*My fee schedule as of January<sup>1</sup>, 2008 is below*

|  |              |
|--|--------------|
| <i>1 hr - 1hr, 20 min Initial Evaluation</i> | <i>\$200</i> |
| <i>45-50 Minute Therapy Session</i>          | <i>\$150</i> |
| <i>20 Minute Medication Management</i>       | <i>\$95</i>  |

If after beginning treatment you feel you are unable to meet the expense of treatment under the fee schedule, please feel free to discuss your circumstances with me.

### **Cancellations and Missed Appointments**

In order to provide high quality and attentive care I intentionally carry a moderate number of patients. When we make an appointment that time is reserved solely for you. It is not feasible financially to go unpaid for time reserved specifically for one individual. If you must cancel an appointment, kindly do so forty eight hours before. For appointments cancelled with less than 48 notice or missed without notice the regular fee will be charged. No charge will be made in the event of an emergency.

### **Contacting Dr. Ambrose**

I provide coverage for emergencies 24 hours per day, 365 days per year. In the event that I am out of town, the office answering machine will list contact information for a physician covering for me.

For routine matters, please leave a message on the office phone number, (410) 884-1555, and I will get back to you as soon as possible, generally by the end of business day. Routine messages left after hours and on weekends will be returned the next business day. For urgent or emergent issues, please call the office first and if you do not reach me there, call (443) 226-2627. If you are unable to call or cannot wait for a call back please go to the nearest Emergency Room and have the doctor there contact me.

*Again, please do not hesitate to contact me in case of an emergency.*

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**Acknowledgement of Policies**

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*Feel free to ask any questions the attached policies. Your signature indicates that you have read, understood, and will abide by them. Thank you and I look forward to working with you.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Referral Information**

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**How were you referred to Dr. Ambrose?**

- |   |   |
|---|---|
| <input type="checkbox"/> Primary Care Doctor; Dr. _____   | <input type="checkbox"/> Therapist; Name: _____ |
| <input type="checkbox"/> webpage ( <a href="http://www.columbiapsychiatry.com">www.columbiapsychiatry.com</a> ) | <input type="checkbox"/> phonebook              |
| <input type="checkbox"/> friend/family/acquaintance   | <input type="checkbox"/> other: _____           |

If referred by a therapist or physician, may Dr. Ambrose contact thme?  Yes ;  No

**Patient Contact Information**

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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Employer: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ May we leave a message? Yes \_\_\_ No \_\_\_

Alternate Phone: \_\_\_\_\_ May we leave a message? Yes \_\_\_ No \_\_\_

**Emergency Contact Information**

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Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Alternate Phone: \_\_\_\_\_

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**Medical History**

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**Current Medications:** \_\_\_\_\_

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**Medication Allergies:** \_\_\_\_\_ **Prior Surgeries:** \_\_\_\_\_

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**Current Medical Issues:** \_\_\_\_\_

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**Significant Past Medical History (Indicate with a check where applicable and explain below where necessary.)**

|                     |                          |                     |                          |
|---------------------|--------------------------|---------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | Heart Disease       | <input type="checkbox"/> |
| High Cholesterol    | <input type="checkbox"/> | Stroke              | <input type="checkbox"/> |
| Thyroid Problems    | <input type="checkbox"/> | Liver Disease       | <input type="checkbox"/> |
| Kidney Disease      | <input type="checkbox"/> | Neurologic Disorder | <input type="checkbox"/> |
| Seizures            | <input type="checkbox"/> | Migraines/Headaches | <input type="checkbox"/> |
| Glaucoma            | <input type="checkbox"/> | Diabetes            | <input type="checkbox"/> |
| Cancer              | <input type="checkbox"/> | Immune Problems     | <input type="checkbox"/> |
| Chronic Pain        | <input type="checkbox"/> | Head Trauma         | <input type="checkbox"/> |
| Reproductive Issues | <input type="checkbox"/> | Sexual Dysfunction  | <input type="checkbox"/> |

**Other/Further Details:** \_\_\_\_\_

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**Do you smoke?** ( ) No; ( ) Yes How many cigarettes per day? \_\_\_\_\_ For how long? \_\_\_\_\_

**On average, how many times a week do you drink?** \_\_\_\_\_ On average, how many drinks in total do you consume in a week? \_\_\_\_\_ Are you concerned about your alcohol use? \_\_\_\_\_

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**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

**Address: (City and state if street address unknown.)** \_\_\_\_\_

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