Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

FINANCIAL POLICY

We are committed to providing high-quality care while maintaining transparency in financial expectations. Please review and acknowledge the following policies:

Payment Policy

Payment is due at check-in for all services, including co-pays, deductibles, and outstanding balances.
Accepted forms of payment: **Cash, Visa, MasterCard, and American Express.**
Checks are not accepted. If a check is presented, the appointment will be rescheduled until a valid form of payment is available.

Insurance Policy

As a courtesy, we will file claims with insurance companies **only if we are in-network with your plan.**
A valid **insurance card and photo ID** are required to submit claims on your behalf.
You are financially responsible for all charges not covered by your insurance, including if:

- Your plan denies the claim,
- You have not met your deductible,
- The services are considered non-covered or not medically necessary.

Out-of-Network Policy: If we are not contracted with your insurance, **full payment is due at the time of service**. We do not submit claims for out-of-network plans.
Unpaid Claims: If insurance does not pay within 90 days, the full balance becomes your responsibility.
Pre-Authorizations: Many insurance plans require prior authorization for mental health or substance use services. It is your responsibility to obtain these. Failure to do so may result in full financial responsibility.
If your insurance restricts payment for services, you waive those restrictions by signing this policy.

Medicare Notice

We are **not enrolled** with Medicare. Medicare patients will be charged self-pay rates:

Psychiatric Evaluation (99205): $300
Medication Management (99214): $125 (additional fees may apply for extended appointments)
Therapy/Extended Appointment (90833): $50

Minor Patients

A **parent or legal guardian** must accompany patients under 18 and be prepared to pay at the time of service.
We do not bill third parties who are not present, regardless of legal or court-ordered agreements.
It is the accompanying adult's responsibility to seek reimbursement from other responsible parties.
Unaccompanied minors will not be seen unless prior arrangements are made.

Missed Appointments / No-Shows

Appointments must be canceled with at least **24 hours' notice** to avoid fees.
No-show fees (not covered by insurance) are as follows:
Follow-up Appointment: $50
New Patient or Therapy Appointment: $100

Other Charges

Administrative fees apply for forms and letters (e.g., FMLA, disability paperwork, treatment summaries, facility applications).
Fees range from **$25 to $250**, based on complexity and time required.

Account Balances

Self-pay patients must pay any outstanding balance in full before receiving additional treatment.
Patients with balances over **$100** must pay balance before scheduling future appointments.
For payment plan options, please contact our billing department to review your account.

Patient Signature or Legally Authorized Representative _____ Date _____

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

FDA ADVISORY & CLINICAL WORSENING/SUICIDE RISK

The U.S. Food and Drug Administration (FDA) has issued a public advisory requiring that antidepressant medications carry warnings about the potential for worsening of depression and the emergence of suicidal thoughts or behaviors, especially in children, adolescents, and young adults. We are providing this information to make you aware of the FDA warning and to **stress the importance of monitoring of the patient while taking antidepressants**. Monitoring of the patient by our office will be handled regularly scheduled follow up appointments. **It is imperative that you keep follow up appointments as requested by the physician**. If there is need to inform the physician of a dramatic worsening in symptoms or if there are concerns that arise prior to the scheduled appointment, you are asked to contact our office.

Patients with Major Depressive Disorder (MDD)—regardless of whether they are taking medication—may experience symptom worsening or suicidality, particularly during the early phases of treatment or during dosage changes. Therefore, close monitoring is essential.

Symptoms to monitor include:

- Anxiety, agitation, panic attacks
- Insomnia, irritability, impulsivity
- Hostility, restlessness (akathisia)
- Hypomania or mania

These symptoms, even if not linked directly to antidepressants, may signal a need to reassess treatment. Caregivers and family members should observe for any sudden changes in mood, behavior, or functioning and report concerns immediately.

In some cases, a depressive episode may be the first indication of Bipolar Disorder. Treating such episodes with antidepressants alone may increase the risk of a manic or mixed episode in vulnerable individuals.

Our office will monitor patients through regularly scheduled follow-up appointments, which are vital for your safety and treatment success. Please keep all appointments as scheduled. If symptoms worsen significantly or new concerns arise before your next visit, contact our office immediately.

A major depressive episode may be the initial presentation of Bipolar Disorder. It is generally believed (though not established in controlled trials) that treating such an episode with antidepressant alone may increase the likelihood of precipitation of a mixed/main episode in patients at risk for Bipolar Disorder. Whether any of the symptoms described above represent such conversion is unknown.

Decision to start antidepressant therapy has been based on the **benefit vs risk ratio**. You as patient or guardian/parent of the patient have agreed to this course of therapy knowing the possible risks associated with these treatments.

Parental Consent & Monitoring in Shared Custody Cases

In situations involving divorced or separated parents, the parent or legal guardian who initiates or accompanies the child for treatment is responsible for informing the other parent of the nature, risks, and purpose of antidepressant therapy.

Please be advised that:

- **Our practice does not act as mediators in custody disputes** and will follow the instructions of the parent or guardian who presents with the child unless **instructed otherwise by a court order on file.**
  The attending parent is expected to ensure that all legal and consent obligations are **fulfilled under their custody or court agreemen**
  If both parents have joint legal custody, we recommend that both be informed and in agreement regarding treatment. Both parents should also be present for appointments when possible. Any disputes regarding treatment decisions should be resolved between the parents or through the legal system.
- Parents are expected to manage communication and compliance with legal agreements independently; **our staff does not engage in family legal matters.**

t

Patient Signature or Legally Authorized Representative

Date

RIVERVIEW | 6332 US Hwy 301 S, Riverview, FL 33578 | P: (813) 662-5919 | F: (813) 671-8374
TAMPA | 3333 W. Kennedy Blvd, Suite 106, Tampa, FL 33609
MIAMI | 2600 S. Douglas Rd, Suite 711, Coral Gables, FL 33134 | P: (305) 686-5150

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

Child, Adolescent, & Adult Psychiatry

Authorization for Verbal Communication and/or to Leave Voicemail Messages

(This does NOT authorize release of copies of medical records)

Patient Name: _____

Date of Birth: _____
Month/ Day/ Year

Patient Authorization: I hereby authorize Embracing Life Wellness Center to leave detailed, personal health information by the following means:

- o Voicemail message at my home number: _____ (area code and number)
- o Voicemail message at my work number: _____ (area code and number)
- o Voicemail message on my cellular phone: _____ (area code and number)
- o Voicemail at a different location: _____ (area code and number)
- o Verbal message with my spouse or partner: _____ (name of spouse or partner)

  _____ (area code and number)
- o Verbal message with other family member: _____ (name of family member)

  _____ (area code and number)
- o Other: _____

With my signature below, I acknowledge and understand that this authorization will be kept in my medical record and that the communication parameters listed above will remain in effect until revoked by me in writing. It is my responsibility to notify Embracing Life Wellness Center in writing should I wish to change one or more of the telephone numbers and/or contacts listed above.

_____ _____

Patient Signature or Legally Authorized Representative Date

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

Patient's Name: _____

As the patient or legal guardian, I agree to accept the terms of this patient code of conduct agreement.

INITIAL EACH LINE

Please initial each line to acknowledge understanding and agreement.

_____ I will attend all scheduled appointments and arrive on time.

_____ I understand that frequent missed or late-cancelled appointments may result in dismissal from the practice. This includes two consecutive no-shows or three no-shows within a year.

_____ I will promptly notify the office of any changes to my personal information (e.g., name, address, phone number, or insurance coverage).

_____ I understand that I can contact the office by phone Monday–Friday from 8:00 AM to 5:00 PM. An after-hours answering service is available on evenings, Fridays, weekends, and holidays. For emergencies, I will call 911. I may also email the office at emlife@embracinglifetoday.com during regular business hours.

_____ Due to limited waiting room space, I agree to attend appointments alone or with one supportive advocate if needed. I will arrange childcare in advance. If accompanying a minor, I will only bring the child with the scheduled appointment.

_____ If I accompany a minor, I will supervise them at all times while in the office to ensure appropriate behavior.

_____ I agree to follow the office's payment policies and maintain my account in good standing.

_____ I understand that a therapy code may be added if my visit extends beyond 15–20 minutes, which may include an additional billing code and charge.

_____ I will treat all staff and providers with respect and courtesy at all times.

_____ I understand that any disruptive, disrespectful, or threatening behavior may result in the termination of my care.

_____ I will respect the rights, space, and property of other patients and staff.

_____ I will not sell, share, or give my prescribed medications to anyone. I understand this is a serious violation and grounds for immediate termination without appeal.

_____ I will not engage in illegal, disruptive, or inappropriate conduct while on the premises.

_____ I accept full responsibility for my prescribed medications and will keep them secure. I understand that lost or stolen medications will not be replaced.

_____ I understand that Schedule II medications (e.g., stimulants) will not be refilled over weekends and that early refills are not allowed.

_____ I will not seek controlled substances from other providers or pharmacies without informing my provider.

_____ I will take my medications exactly as prescribed and will consult my provider before making any changes.

_____ I understand that medication alone may not be sufficient treatment. I agree to participate in counseling or therapy as outlined in my treatment plan.

_____ I acknowledge that violations of this agreement may result in the discontinuation of services.

_____ Date _____

_____ _____

Patient Signature or Legally Authorized Representative

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____ Patient Name:_____ DOB:_____/_____/_____

This authorization will allow Embracing Life Wellness Center, P.A. and it's practitioners to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

PRIMARY CARE PROVIDER:

_____

(Name of Agency/ Organization/ Professional or Individual)

_____

Address Information

_____

Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Embracing Life cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

PLEASE CHECK ALL THE APPLY BELOW

___Physician Discharge Summary	___Psychological Evaluation	___Medical History
___History/ Physical Examination	___Psychiatric Evaluation	___Lab Results
___Consultation	___Progress Notes	___Diagnosis
___Recommendation for Treatment & Care	___Treatment Plans	___Verbal Communications
___Psychiatric Discharge Summary	___Billing Records	___Insurance Coverage Info
	_____ENTIRE FILE	

Other Information:_____

The purpose for the release and disclosure of this protected health information if for:

___Continuation of Care ___Coordination of Care/Treatment ___Other:_____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as valid as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Embracing Life is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program to which the disclosure is made has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization is made by the patient or patient's guardian and provided to Embracing Life Wellness Center. This authorization shall remain valid for the duration for which the patient is receiving care and treatment at Embracing Life Wellness Center. Voluntary cessation of treatment or if the patient is discharged from the practice involuntarily will terminate the validity of this release.

_____ _____
Patient Signature (If patient is over the age of 18) Date

_____ _____
Legally Authorized Representative's Signature Date

_____ _____
Witness Signature Date

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

AUTHORIZATION FOR RELEASE OF INFORMATION

Date:_____ Patient Name:_____ DOB:_____/_____/_____

This authorization will allow Embracing Life Wellness Center P.A and its practitioners to exchange general medical as well as psychiatric/ alcohol/ drug abuse/ HIV/ and or AIDS information from my health record in accordance with Florida Statutes 394, 459, 90.503, 394.4615, 397.501 and Federal Regulations (42 CFR Part 2) with:

INSURANCE COMPANY NAME ONLY:

(Name of Agency/ Organization/ Professional or Individual)

Located on the Back of the Card

Address Information

Located on the Back of the Card

Telephone Number/ Fax Number

I hereby authorize the use or disclosure of my individually identifiable health/ psychiatric/ mental health information as described below. I understand that the information I authorize any person or entity to receive or collect about me may be re-disclosed and no longer protected by federal privacy regulations. I understand the office of Embracing Life cannot guarantee the privacy of my records once they have been released to an outside party and shall be held harmless from any liability or negligence from the re-disclosure or release of my records.

PLEASE CHECK ALL THE APPLY BELOW

___Physician Discharge Summary	___Psychological Evaluation	___Medical History
___History/ Physical Examination	___Psychiatric Evaluation	___Lab Results
___Consultation	___Progress Notes	___Diagnosis
___Recommendation for Treatment & Care	___Treatment Plans	___Verbal Communications
___Psychiatric Discharge Summary	_X_Billing Records	_X_Insurance Coverage Info
	_____ENTIRE FILE	

Other Information:_____

The purpose for the release and disclosure of this protected health information if for:

___Continuation of Care ___Coordination of Care/Treatment ___Other:_____

A general medical authorization or subpoena duces tecum without a specific authorization provided to release psychiatric/ alcohol/ drug abuse/ HIV and or AIDS information must have this waiver from the patient or his/her legally authorized representative. A copy of this authorization shall be considered as valid as an original signed copy. I understand that I have a right to refuse this authorization. If I approve, I further understand that Embracing Life is released from all legal liability arising from the release of the information requested. Treatment will not be conditioned on the provision of a signed authorization except as permitted by law.

Prohibition on Redisclosure:

This information has been disclosed to you from the records whose confidentiality is protected by Federal law. Any further re-disclosure is strictly prohibited. These records may be protected by Federal Regulation (42CFR Part2). This consent is subject to revocation at any time, except to the extent that the program to which the disclosure is made has already taken action in reliance upon it. This authorization will remain valid until written revocation of the authorization is made by the patient or patient's guardian and provided to Embracing Life Wellness Center. This authorization shall remain valid for the duration for which the patient is receiving care and treatment at Embracing Life Wellness Center. Voluntary cessation of treatment or if the patient is discharged from the practice involuntarily will terminate the validity of this release.

_____ _____
Patient Signature (If patient is over the age of 18) Date

_____ _____
Legally Authorized Representative's Signature Date

_____ _____
Witness Signature Date

Embracing Life

Melissa Fickey, M.D.

SARAH CASH, ARNP • TIFFANY JOSEPH, ARNP
SAMANTHA FARRELL, ARNP • NATALIE LEN, ARNP • JACKLYN LERNER, ARNP

Patient Name:_____ Date:_____

TELEMEDICINE CONSENT FORM

1. I understand that my healthcare provider has recommended a telemedicine consultation, which uses secure video technology to provide care when an in-person visit is not possible.
2. I acknowledge that telemedicine is not the same as a face-to-face visit, as I will not be in the same physical location as my provider.
3. I understand the potential risks of telemedicine, including technical issues, interruptions, and unauthorized access. I understand that either my provider or I can discontinue the session if the video connection is inadequate.
4. I understand that my healthcare information may be shared with staff involved in scheduling or billing. In rare cases, technical support staff may be present to assist with the equipment. These individuals will maintain confidentiality, and I have the right to:
    a. Omit sensitive information during the visit.
    b. Request that non-medical personnel leave the room.
    c. End the session at any time.
5. I understand that billing will be submitted by my provider as with an in-person visit.
6. I confirm that I have had an opportunity to ask questions about telemedicine, and these questions have been answered in a way I understand. The risks, benefits, and alternatives have been explained to me.

By signing this form, I certify:

- have read (or had read to me) and fully understand this form.
- I have had the opportunity to ask questions, and all questions have been answered to my satisfaction.

_____ _____

Patient Signature/Parent or Guardian Date

_____ _____

Witness Signature Date