Practice Policies and Agreement

Confidentiality:
Privacy is important to teenagers, and as such, children between 13 and 18 years of age have the right to confidentiality. There are exceptions, however. Information will be shared without confidentiality release in cases in which there is suspected child abuse, when the child is a danger to others, or in situations in which a child may be placing themselves in a potentially dangerous situation (e.g. significant substance abuse). Practicality speaking, parents and family are critical to treatment planning and are kept in close communication. Nonetheless, if an adolescent requests confidentiality outside of the above potentially dangerous areas, Dr. Webster will attempt to help the teenager with the issue at hand, and with how to most appropriately to involve their parents. Privacy is of upmost importance for adequate therapeutic work to occur with children and adolescents. Your support of this in your role as parent is critical to their treatment.

Other areas of confidentiality include insurance. Please note that if you chose to request reimbursement from your insurance, your information will be shared with your insurance company in accordance with the agreement and policies set between your insurance company and you. At a minimum, insurance companies require a type of service provided and diagnosis codes. Lastly, if outstanding balances are not paid and not addressed, treatment information will be released for collection agency involvement.

Appointments:
Appointments can be made by telephone at 617.859.5953.

Cancellation Policy:
Appointment times are reserved for you in advance. Regular follow-up visits, particularly for medication monitoring, are necessary to provide safe medical care. A minimum of 2 business days (48 hours) notice for cancellations are required. Monday appointments need to be cancelled by 5 pm the preceding Thursday. Appointments that are missed without 48 hours notice will be charged at the full session rate.

Voicemail/Messages:
Keeping in contact is vital. As such, voicemails are frequently accessed. Your voicemail will be returned within 24 hours during business days after review of your medical record. Calls left late on Friday will most likely be processed Monday.

Emergencies:
For life threatening emergencies, please call 911 or go to your nearest emergency room. For urgent matters, please call the office, leave a message, and follow the instructions for contacting Dr. Webster or a covering psychiatrist if Dr. Webster is away. As a reminder, Dr. Webster does not guarantee email responses within a certain period of time and that any urgent or emergent needs must be communicated via telephone. Outpatient clinics have limitations. Therefore, please note that Dr.

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Webster may not be able to return your call immediately. You may call an outside crisis line 24 hours/ day, 7 days/week at 1.877.870.4673, call 911, or go to the nearest ER.

Telephone calls:
Dr. Webster provides face to face care, but urges families to call for any major medication side effects or new concerning behaviors. Generally issues that require more than brief management or recommendations will require an office visit. For any call 15 minutes or longer, or when required by the situation, or requested for convenience, Dr. Webster will provide more extended services over the phone based on my hourly rate of $350.

Collateral telephone calls:
Child and Adolescent Psychiatry often entails significant time outside of appointment times coordinating care with other mental health providers, discussing impressions with other therapists and teachers, and managing medical concerns in concert with primary care physicians. Equally for adults, coordinating care with primary care physicians and others responsible for adult care, vastly increases the quality of care you or your child receives. Dr. Webster makes every effort to contacting him securely via his website, by fax, or by mail as seamless as possible.

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Refills:
In general refills are provided as are reasonable given the stability of the patient and frequency of monitoring needed. Refills may be conveniently requested by the Patient Portal (www.valantmed.com/Portal/cecilwebstermd). You may also have your pharmacy fax a refill request form or leave a message by phone although these methods are typically slower. If your condition requires monitoring and the time since your last appointment has been longer than recommended Dr. Webster may insist on an appointment and will generally provide the patient with enough medication until that appointment. In general visits are frequent upon treatment initiation and then become less frequent as stability is achieved. Refills provided generally follows that pattern as well.

Patient Records:
You may request your medical records at your own expense and request that factual errors be corrected. Parts of your record that could potentially be more detrimental than helpful to your psychological well-being, or that were asked to be kept confidential by the provider, may be withheld. These records will be kept as long as possible. You may authorize in writing that copies of these records be released to entities you designate. Records sent to other mental health care providers, primary care providers, therapists, for purposes of an education evaluation, psychological testing, or other mental health treatment will be provided free of charge unless record is unusually large (>100 pages) for which a nominal fee will be charged (depending on delivery method). Records for other purposes including personal or legal reasons will be charged based on a per page amount and the closest flat rate priority mail shipping option.

Fees (as of April 2021):

Initial Consultation	80 min	$850
Psychotherapy	50 min	$350
Psychotherapy with medication management	50 min	$350
Psychopharmacology management	20 min	$230
Forensic and School Safety Evaluations	2+ hours	Request

Fees are subject to change and subject to 5% annual increase on or around March 1st
Returned checks will be assessed $30 fee

Insurance and Payment:
Since Dr. Webster does not participate in insurance plans, it is your responsibility to verify that your plan will cover services. Insurance involvement is limited as they often govern the type, frequency, and amount of care, which may impair your ability to receive optimal treatment and privacy. Statements outlining services are provided monthly at the most appropriate insurance billable codes; however some treatments may not be covered by insurance. Payment of services, including non covered services, is the patient's responsibility. In split custody situations, the parent initiating treatment is ultimately responsible for payment.

Billing:
Face to face and remote services are billed at time of service, and other services weekly. Detailed statements are sent out weekly. Credit card, check, Zelle, and cash payments are accepted and receipt of services are provided.

Agreement:
I have read the above practice policies and have had opportunity to have any questions answered. I understand that policies and fees may change in time and I will be updated on any major changes. Documents are available at www.cecilwebstermd.com. I have read and acknowledge receipt of Dr. Webster's notice of privacy practices (March 2021).

I consent to evaluation and treatment by Dr. Webster and agree to be responsible financially for services rendered.

Signature of Patient (if 16 or older) Date

Signature of Parent/Guardian Relation Date

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Notice of Privacy Policies

As required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your protected health information.

Please review this notice carefully.

Our Commitment to Your Privacy

Our practice is dedicated to maintaining the privacy of your individually identifiable health information. In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your protected health information (PHI). By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your PHI
- Your privacy rights in your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. You may request a copy of our most current Notice at any time.

If You Have Questions About This Notice, Please Contact:

Cecil R. Webster, Jr., M.D.
137 Newbury Street, 6th Floor
Boston, Massachusetts 02116

We May Use and Disclose Your Protected Health Information (PHI) in the Following Ways:

1. Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have

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laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your PHI in order to write a prescription for you, or we might disclose your PHI to a pharmacy when we order a prescription for you. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children or parents.
Finally, we may also disclose your PHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items. We may disclose your PHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations. The practice may call you by name in the waiting room when your physician is ready to see you.

4. Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment. This includes the leaving of appointment reminder information on your telephone answering machine, SMS, or email.

5. Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

7. Release of Information to Family/Friends. Our practice may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you.

8. Disclosures Required By Law. Our practice will use and disclose your PHI when we are required to do so by federal, state or local law.

Use and Disclosure of Your PHI in Certain Special Circumstances:

1. Public Health Risks. Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:

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- maintaining vital records, such as births and deaths
- reporting child abuse or neglect
- preventing or controlling disease, injury or disability
- notifying a person regarding potential exposure to a communicable disease
- notifying a person regarding a potential risk for spreading or contracting a disease or condition
- reporting reactions to drugs or problems with products or devices
- notifying individuals if a product or device they may be using has been recalled
- notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information
- notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.

3. Lawsuits and Similar Proceedings. Our practice may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release PHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement
- Concerning a death we believe has resulted from criminal conduct
- Regarding criminal conduct at our offices
- In response to a warrant, summons, court order, subpoena or similar legal process
- To identify/locate a suspect, material witness, fugitive or missing person
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

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5. Deceased Patients. Our practice may release PHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs.

6. Organ and Tissue Donation. Our practice may release your PHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

7. Research. Our practice may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes except when an Institutional Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your PHI if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Workers' Compensation. Our practice may release your PHI for workers' compensation and similar programs.

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Your Rights Regarding Your PHI:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to **Cecil Webster, M.D.** specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give a reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. **We are not required to agree to your request;** however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of your PHI, you must make your request in writing to **Cecil Webster, M.D.** Your request must describe in a clear and concise fashion: (a) the information you wish restricted; (b) whether you are requesting to limit our practice's use, disclosure or both; and (c) to whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to **Cecil Webster, M.D.** in order to inspect and/or obtain a copy of your PHI. Our practice will need to charge a fee for the costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chosen by us will conduct reviews.

4. Amendment. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to **Cecil Webster, M.D.** You must provide us with a reason that supports your request for amendment. Our practice will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion: (a) accurate and complete; (b) not part of the PHI kept by or for the practice; (c) not part of the PHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request an "accounting of disclosures." An "accounting of disclosures" is a list of certain non-routine disclosures our practice has made of your PHI for non-treatment, non-payment or non-operations purposes. Use of your PHI as part of the routine patient care in our practice is not required to be documented. For

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example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your request in writing to **Cecil Webster, M.D.** All requests for an "accounting of disclosures" must state a time period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 1, 2014. The first list you request within a 12-month period is free of charge, but our practice will need to charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact **Cecil Webster, M.D.**

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact **Cecil Webster, M.D.** All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. Right to Provide an Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to us regarding the use and disclosure of your PHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

This notice is effective on May 1, 2014.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact **Cecil Webster, M.D.**

_____

Signature of Patient (or Parent if minor) Relation Date

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CECIL R. WEBSTER, JR., M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Authorization to Obtain, Use, and Disclose Protected Health Information

Patient Name: _____
last *first* *middle*

Home Address: _____

_____
city *state* *zip*

Home Telephone: _____ Date of Birth: _____

I authorize Cecil Webster, MD and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment, or coordinating care unless specified otherwise below.

Child's School: _____
school name *counselor's name*

Address: _____

_____
city *state* *zip*

Office Telephone: _____ Fax Number: _____

Information Covered Under This Release

____ Entire medical record
(e.g., discharge summaries, lab data, and information from a primary care physician)

____ Ongoing communication regarding psychiatric or mental health care
(e.g., ongoing care with a primary care physician or mental health provider)

____ Information regarding the academic or behavioral performance of child in school
(e.g., ongoing communication with teachers, school psychological testing, Individual Education Plans)

____ Psychological testing

____ Information for referral purposes

____ Other (please specify) _____

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CECIL R. WEBSTER, JR., M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Highly Confidential Information

____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is:

Medical care:_____ Legal Matter:_____ Insurance:_____ Personal:_____

This authorization expires:

____ Termination of treatment with Dr. Webster

____ 90 days from the date signed

____ On specified date, reason or event (specify) _____

By my signature below, I hereby authorize Cecil Webster, MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once Cecil Webster, MD discloses my health information to the recipient, Cecil Webster, MD cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr. Webster's treatment of me; except, however, if my treatment by Dr. Webster is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr. Webster may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cecil Webster, MD. the revocation will be effective immediately upon Cecil Webster, MD's receipt of my written notice, except that the revocation will not have any effect on any action taken by Cecil Webster in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize Cecil Webster, MD to obtain use and/or disclose my health information in the manner described above.

Signature of Patient (or Parent/Guardian if minor) Relation Date

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CECIL R. WEBSTER, JR., M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Authorization to Obtain, Use, and Disclose Protected Health Information

Patient Name: _____
last *first* *middle*

Home Address: _____

_____
city *state* *zip*

Home Telephone: _____ Date of Birth: _____

I authorize Cecil Webster, MD and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment, or coordinating care unless specified otherwise below.

Name/Facility: _____
(e.g. PCP, therapist)

Address: _____

_____
city *state* *zip*

Office Telephone: _____ Fax Number: _____

Information Covered Under This Release

____ Entire medical record
(e.g., discharge summaries, lab data, and information from a primary care physician)

____ Ongoing communication regarding psychiatric or mental health care
(e.g., ongoing care with a primary care physician or mental health provider)

____ Information regarding the academic or behavioral performance of child in school
(e.g., ongoing communication with teachers, school psychological testing, Individual Education Plans)

____ Psychological testing

____ Information for referral purposes

____ Other (please specify) _____

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CECIL R. WEBSTER, JR., M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Highly Confidential Information

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____ 90 days from the date signed

____ On specified date, reason or event (specify) _____

By my signature below, I hereby authorize Cecil Webster, MD to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once Cecil Webster, MD discloses my health information to the recipient, Cecil Webster, MD cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of Dr. Webster's treatment of me; except, however, if my treatment by Dr. Webster is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Dr. Webster may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Cecil Webster, MD. the revocation will be effective immediately upon Cecil Webster, MD's receipt of my written notice, except that the revocation will not have any effect on any action taken by Cecil Webster in reliance on this Authorization before it received my written notice of revocation.

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize Cecil Webster, MD to obtain use and/or disclose my health information in the manner described above.

Signature of Patient (or Parent/Guardian if minor) Relation Date

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CECIL R. WEBSTER, JR., M.D.

Adult, Adolescent, and Child Psychiatry & Psychotherapy

Informed Consent for using email to communicate with Dr. Webster

Patient Name: _____/____/_____
last first middle DOB

Parent Name: _____
(if minor) last first middle

Requested Email(s): _____

I, the undersigned, certify that I am requesting communication with Dr. Webster via electronic mail (email). Risk definitely exists that any protected health information contained in such email may be disclosed to, or intercepted by, unauthorized third parties. By signing this document, I acknowledge and understand this risk. I also acknowledge and understand that other, more secure methods of communication with Dr. Webster exist, including communication via telephone, fax, or non-electronic written communication. **Finally, I acknowledge and understand that Dr. Webster does not guarantee response within a certain period of time and that any urgent or emergent needs must be communicated via telephone.**

_____
Signature of Patient (if 16 or older) Date

_____
Signature of Parent/Guardian Relation Date

Dr. Webster will use the minimum necessary amount of protected health information to respond to your query.

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