STEPS/FORMS TO SEE DR. SENIOR

The following steps and/or forms must be completed in order to be scheduled to see Dr. Senior, the psychiatrist who comes to Landmark College once a week to meet with scheduled students for medication management.

Required Steps/Forms:

Before your appointment with Dr. Senior

1. **Request to see a counselor –** Request for counseling is done online by using the web access https://titanium.landmark.edu/tiweb/WCMenu.aspx. This address is only accessible while connected to the Landmark College network.

2. **Meet with the counselor -** Reply to counselor's appointment request and attend the appointment (make sure to let the counselor know that you wish to meet with Dr. Senior). The counselor will discuss your needs for counseling in addition to meeting Dr. Senior. Dr. Senior may also recommend ongoing counseling in conjunction with medication management.

3. **Complete *Registration and Billing Form* (for Dr. Senior's office) -** This form must be filled out by the student and the person responsible for paying the bills. *This form is required to be filled out every academic year*

4. **Complete *Credit Card Form* (for Dr. Senior's office) -** This form must be filled out by the student and the person responsible for paying the bills. This will be kept on file in Matrix Billing Office. *This form is required to be filled out every academic year*

5. **Check Landmark College Email for appointment** – Appointments with Dr. Senior will be scheduled and sent to you over the Landmark College Email as an appointment

At your appointment with Dr. Senior

1. **Sign the *Acknowledgement of Receipt of Notice of Privacy Practices* (for Dr. Senior's chart). -** This is done at the first appointment. The Counseling Office Coordinator will give the student the *Notice of Privacy Practices* from Dr. Senior's office and have the student sign the receipt.

Recommended Steps/Forms:

1. **Fill out Authorization to Exchange Information form (for Dr. Senior's office) -** This form must be filled out by the student in order for Dr. Senior to speak to other clinicians and/or parents.

2. **Fill out Authorization to Release Information (for Matrix Health Systems, PC & its liaison at Landmark College) -** This form must be filled out by the student in order for family members/guarantor to discuss billing issues and/or appointment times and attendance.

Matrix Health Systems, PC
80 Linden Street
Brattleboro, VT 05301
802 254-2291

August 18, 2016

Dear Landmark Students and Family Members:

For the convenience of Landmark students, Dr. Neil Senior, a board certified adult and child/adolescent psychiatrist, comes to the Landmark campus weekly to provide assessment and medication management services.

Dr. Senior is employed by Matrix Health Systems, PC a private Behavioral Health Practice that charges Landmark students or family members directly for his services at the time of appointments.

Payments can be made by credit card, health savings credit cards, cash or check. A credit card form is attached for your convenience. Payment is due at the time of services. Matrix Health Systems, PC does not bill Health Insurances for your visit.

Matrix Health Systems, PC will provide you with the paperwork to submit to your insurance company to facilitate the reimbursement to you. All communication with insurers regarding approval for services and reimbursement is the responsibility of the student or family.

Scheduling is done through the Landmark Counseling Department.

Rates for services are:

1. Assessment - $200
2. Medication Management - $90
3. No-shows will be billed at 100% of the scheduled appointment fee.
   (please call 24 hours in advance to change or reschedule your appointment)

If you have any questions please contact Cindy Brown at the Landmark Counseling Department, 802-387-1636 or I can be reached at our office in Brattleboro, VT @ 802-254-2291 extension. 210.

Sincerely,

Lorrie Massari
Office Manager

Matrix Health Systems, PC
Registration Form and Billing Information
Academic Year 2017-18
Telephone: 802-254-2291

Student Information- Section 1

Last Name ______________________________ First Name ______________________

Mailing Address ____

City _________________________ State _____Zip Code ________Telephone # ___________

Date of Birth ______________ Social Security # ____________________ Sex __________

Local Student Phone number _______________________

Insurance Information- Section 2

Primary Insurance __________________________________ Telephone # ______________

Mailing Address ____

____

Subscriber Name __________________________________ Relationship to Above ____________

Certificate # ____________________________________ Group # ________________________

Signature of Parent/ Guarantor ____________________________________ Date _____________
(Signature of responsible party)

Secondary Insurance __________________________________ Telephone # ______________

Mailing Address ____

____

Subscriber Name __________________________________ Relationship to Above ____________

Certificate # ____________________________________ Group # ________________________

Signature of Parent/ Guarantor ____________________________________ Date _____________
(Signature of responsible party)

____

(Student Signature for release of information)

Date

Academic Year 2017-18

Parent/Guarantor Information/ Billing Information- Section 3

Guarantor Name ____
(Name of responsible party for payment)

Mailing Address____

____

Relationship to student _____________________ Day Time Telephone # _________________

Student Name ____

______ **I agree to pay for the services provided and will accept payment directly from my insurance company.**

____
Guarantor signature

Matrix Health Systems, PC will provide forms to you to be sent into your primary insurance company, if you have provided insurance information. We do not bill insurance.

Fee Schedule:

1. Initial Appointment Fee is $200.00
2. Follow Up Appointment Fee is $90.00
3. No Show Rate is 100% of scheduled appointment
   (please call 24 hours in advance to change or reschedule your appointment)

Special Notes:

1. There has been confusion in the past with insurance companies regarding "in network" and "out of network" coverage for Dr. Senior. His service addresses do not include Landmark College and we have made the decision not to add Landmark as a location due the number of different insurances involved. We appreciate your understanding around this issue. With this in mind and knowing how expensive health insurance can be we will provide you the appropriate claim forms to be submitted to your insurance following the process listed below.

2. You supply Matrix Health Systems, PC with your primary insurance information prior to the first appointment with Dr. Senior. We will provide you with the standard form so you are able to submit claims to your insurance company and instruct them to pay you directly. If you provide secondary insurance information a form for that insurance will also be sent to you.

______ **I have read the above statements and agree to them.**

____
Guarantor signature

MATRIX HEALTH SYSTEMS/OTTER CREEK ASSOCIATES

80 Linden Street
Brattleboro, VT 05301
802 254-2291

Academic Year 2017-18

Please complete this form for credit card payments

(VISA, MasterCard or Discover only).

Cardholder’s Name:

Cardholder’s Street Address

City, State and Zipcode:

Credit Card Number:

CVC Code:

Expiration Date:

Amount:

Date of Service:

Patient:

Clinician or Program: Neil Senior, MD

Email Address: (Receipt)

For Billing Department:

Batch #:________________________ Date:_____________________________

Academic Year 2017-18

Authorization to Release Information

In order to allow Matrix Health Systems, PC (including its liaison at Landmark College, Cindy Brown) to confirm your appointment time and your attendance and/or to discuss financial issues with your family members or guarantor, you will need to fill out the consent below and sign it.

I, (name) ____ give consent for

Matrix Health Systems, PC to release information specified below to:

Name:____

Contact Information:____

Specific type of information to be disclosed/exchanged

o	Appointment times	o	Financial Issues
o	Attendance at appointments	o	All of the Above

As the person signing this consent, I understand that I am giving my permission to the above-named provider or other named third party for disclosure of confidential health care records. I also understand that I have the right to revoke this consent, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. A copy of this consent and a notation concerning the persons or agencies to who disclosure was made shall be included with my original records. The person who receives the records to which this consent pertains may not redisclose them to anyone else without my separate written consent unless such recipient is a provider who makes a disclosure permitted by law.

This release expires in 12 months unless another date is specified: _________________

Name (Signature): ____

Name (Print): ____

Date: ____

Address: ____

Witness: ____

Authorization to Exchange Information and Medical Records for Dr. Senior

Academic Year 2017-18

I hereby authorize **Dr. Neil Senior, MD** to obtain information from: Name of person/agency with address, telephone & fax number.	I hereby authorize **Dr. Neil Senior, MD** to release information to: Name of person/agency with address, telephone & fax number.
____________________ ____________________ ____________________ ____________________	____________________ ____________________ ____________________ ____________________
Dates of Treatment:	Dates of Treatment:
From to	From to

The specific information to be disclosed is:

Outpatient evaluation and Mental status
Communications for Discharge Planning
Discharge Summary
Lab Reports, X-rays, EEG, EKG, CAT scan
Information re: Legal issues
Return to employment/College letter

Social and Personal history
Treatment Plans
Evaluation Reports
Other: ______________________
____
____

The information is needed for the following purpose: ________________________________
____

I understand that this consent is subject to revocation at any time unless action based on this release has already been taken.

I understand that further disclosure of the information to be disclosed may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2, Confidentiality of Alcohol and Drug Abuse Treatment and Patient Records.)

Unless this consent form is sooner revoked by the undersigned, it will be in effect for 6 months from the date below:

Date: ________ Signature of Patient________________________________ D.O.B. __________

Patient's Name (printed) ________________________________

Relationship to Patient: _______________
____
(if not signed by Parent or Guardian)

Signature of Parent/Guardian:

Signature of Witness:

____

Dr. Neil Senior, MD
Consulting Psychiatrist for Landmark College
C/O Health Services
19 River Rd South
Putney, VT 05346

Phone: 802-387-1636
Fax: **802-387-1644**

For Informational Purposes

Prescription Renewal Requests

When you require renewals from Dr. Senior, please let Cindy Brown (Matrix Health Systems, PC liaison at Landmark College) know **at least 1 week** in advance. We cannot guarantee renewals without advance notice.

You need to provide the following information for all renewals:

1. Your Name
2. Date of Birth
3. Medication Name
4. Dosage
5. Frequency
6. Pharmacy
7. Pharmacy Phone Number

This information is required for verification. If your insurance requires a Prior Authorization, this may delay the refill.

You are responsible for your own prescription medication. If your medication is lost or stolen; Dr. Senior **will not** write an early refill of said prescription.

It is recommended that you safeguard your medication by not leaving it out in the open and keeping your room locked.