Regan Haight, APRN
Family Psychiatric/Mental Health Nurse Practitioner
12569 South 2700 West, Suite 202A, Riverton Utah 84065
Phone: 801-701-1006 Fax: 801-701-1009
Email: reganhaight@gmail.com

GENERAL INFORMATION, FINANCIAL POLICY & INFORMED CONSENT

I am a board certified Family Psychiatric/Mental Health Nurse Practitioner (PMHNP). I can provide a wide range of services to adults, children, adolescents, and their families. PMHNPs diagnose, conduct therapy, and prescribe medications for clients who have psychiatric disorders, medical mental conditions as well as mental health issues arising from environmental and relationship stress. Our initial visit is usually 60 minutes and will entail a psychiatric evaluation to determine diagnosis and possible differential diagnoses, develop a treatment plan that may include medications, individual therapy or a combination of these as well as discussion on lifestyle changes and complimentary healing modalities that may assist you in meeting your goals. I am interested in treating depression, bipolar, anxiety disorders, and perinatal mood disorders as well children with ADHD, depression or mood disorders and anxiety disorders.

ABOUT MEDICATION MANAGEMENT

Medication management with clients who have mental health disorders is a partnership among the client, the prescriber and other mental health professionals that promotes the safe and effective use of medications to help people achieve the best results from their medication. Medication management is often a key part of the recovery process for people who have mental health disorders. A systematic way of deciding what medication could be best will be determined based on best practice research. Results should be monitored so that future decisions about medications can take into account what has happened before. The following are general guidelines for the frequency of visits, with the goal of developing a strong therapeutic relationship and providing you with the best possible care.

Medication management involves an initial appointment, usually 60-70 minutes, to provide comprehensive intake and evaluation. After the initial appointment, frequency is determined by clinical need. If medication is started, ideally the client will contact the physician by email within 2-3 weeks to check-in to inform myself of any progress or problems. A follow-up appointment will be scheduled for 4-6 weeks after the initial evaluation and approximately every 4- 6 weeks following, until satisfactory response to medication is achieved. After stability on medications is reached, the frequency of visits can be decreased to every 3 - 4 months. After a year of remission, appointments are recommended one or two times a year.

Refills: In most cases, refills will not be provided to pharmacies by phone without an appointment and refills will not be initially be allowed in excess of 3-4 months at a time. Please contact the clinic to make an appointment, prior to or, when you pick up your last available refill.

ABOUT PSYCHOTHERAPY

I whole heartedly believe that a complete and holistic approach, which takes into consideration the impact of bio-psycho-social variables, is best in treating and managing mental health issues. It is my hope that you are willing to engage in some other modalities to help you develop insight into your patterns of thinking and behavior. Psychotherapy may involve the development of insight as to how our physical health may be compromised in many ways by emotional and relationship issues. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. It is most successful when there is a mutual rapport. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to one's self and to others. Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. These feelings are important because elements of one's history of important affections and hostilities toward parents and siblings or significant others are often shifted onto the therapist and the process of therapy. Psychotherapy can be relatively short-term (8-16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Clients are urged to consider the risks that major psychological transformation may have on current relationships and the possible need of psychiatric consultation during periods of extreme depression or agitation. Not all people experience improvement from psychotherapy and therapy may be emotionally painful at times. Patients have the right to refuse or to discontinue services at any time.

FINANCIAL RESPONSIBILY

Copayment is due at time of service. Please know what that is. Credit Card information will be kept on file to facilitate this payment without taking time at the beginning of the session.
Fees: Currently I have a fee for service practice, or self pay.
Initial consultation 70-90 minutes for $180.
Medication Management sessions are 20-30 minutes for $80
Psychotherapy visits are 60 minutes for $125.
Psychotherapy and medication management sessions for 60-70 minutes for $150.
Telephone calls may be charged at approximately the same rate as personal consultation.

Note on Insurance Reimbursement: If you have a copayment, please bring that to your appointment. You are responsible to know what your benefits are and what they will cover. You are responsible for all uncovered charges.

CONSENT TO BILL INSURANCE PLAN(S)
My signature below indicates that: I give permission for Regn Haight to bill my insurance company for covered services; and to exchange information necessary to secure payment for these services. Such necessary information may include my diagnosis, service dates, types of services and other information related to the Center's services necessary to process claims. I understand that I am responsible for any balance that my insurance company does not authorize for payment.

Cancellation Policy: Please give 48 hours (2 working days) notice of cancellation, so I may re-schedule the appointment time. For less than 24 hours notice or missed appointments for which I am not notified will be subject to a $60 service charge.

Availability and Urgent needs: The therapist is available for regularly scheduled appointment times. Dates of vacations and other exceptions will be given out in advance if possible. Telephone appointment times can be made by calling the office number during regular office hours. I currently will not have crisis, pager or after-hours services available. If you foresee needing this, or more availability of services, an appropriate referral can be made to other providers/clinics in the community. If unforeseen urgent matters occur, you can leave a message on the clinic voicemail and expect a return call, in most cases, within 24 hours

Emergency number where I can sometimes be reached: 801-701-1006
Emergency service can be obtained by calling 911 or going to the nearest ER department.
UNI Crisis service can also be reached 24/7 at (801) 583-2500.

Termination of Treatment: The therapist may terminate treatment if payment is not timely, if prescriptions are not filled, or if some problem emerges that is not within the scope of competence of the therapist. The usual minimal termination for an ongoing treatment process is four to ten sessions but a satisfying termination to long-term work may take a number of months.

Independent Practice: While I share office space with other mental health professionals our professional practices are independent. I am not partners with, nor do I have any legal association with any other mental health professional.

Agreement for Psychotherapy Consultation
I have read this informed consent completely and have raised any questions I might have about it with my therapist. I have received full and satisfactory response and agree to the provisions freely and without reservations. I understand that my therapist is responsible for maintaining all professional standards set forth in the ethical principles of his/her professional association as well as the laws of the state of Utah governing the practice of psychotherapy and that he/she is liable for infractions of those standards.

Confidentiality: State law and professional ethics require therapists to maintain confidentiality except for the following situations:
1. If there is suspected child abuse, elder abuse, or dependent adult abuse.
2. A situation in which serious threat to a reasonably well-identified victim is communicated to the therapist.
3. When threat to injure or kill oneself is communicated to the therapist.
4. If you are required to sign a release of confidential information by your medical insurance.
5. If you are required to sign a release for psychotherapy records if you are involved in litigation or other matters with private or public agencies. **Think carefully and consult with an attorney before you sign away your rights.**
6. Clients being seen in couple, family, and group work are obligated legally to respect the confidentiality of others. The therapist will exercise discretion (but cannot promise absolute confidentiality) when disclosing private information to other participants in your treatment process. Secrets cannot be kept by the therapist from others involved in your treatment.
7. I may at times speak with professional colleagues about our work without asking permission, but your identity will be disguised.
8. Clients under 18 do not have full confidentiality from their parents.
9. It is also important to be aware of other potential limits to confidentiality that include the following:
a) All records as well as notes on sessions and phone calls can be subject to court subpoena under certain extreme circumstances. Most records are stored in locked files but some are stored in secured electronic devices.
b) Cell phones, portable phones, faxes, and e-mails are used on some occasions.
c) All electronic communication compromises your confidentiality.

Arbitration Agreement
I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL or psychological MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE OF THIS CONTRACT.
Article 1: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by Utah law, and not by lawsuit or resort to court process except as Utah law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures. This agreement constitutes the entirety of our professional contract. Any changes must be signed by both parties. I have a right to keep a copy of this contract.

Your honesty will allow me to begin to understand your unique and personal needs. This information, like all information that you a share with me, is private and confidential. State and professional standards suggest that you be informed of all possible contingencies that might arise in the course of short-and long-term therapy. Please check to be sure you have read, understood, and discussed all questions with me. An informed consent has the force of contract, so we cannot proceed until we reach an agreement on all items.

Client Name (printed)_____Client Signature_____ Date _____

Therapist Signature _____ Date_____

Legal Parent or Guardian Signature _____ Date _____

Credit Card Authorization

Name on card: _____ Credit card Number: _____

Expiration Date: _____ Zip Code: _____ Security code: _____

I authorize Regan Haight PLLC to charge my card for services rendered, no show and late cencelations

Signature: _____