Arnold G. Shapiro, M.D.

1717 Dixie Highway
Lookout Corporate Building, Suite 200
Ft. Wright, Kentucky 41011
(859) 341-7453

8280 Montgomery Road
Kenwood Commons, Suite 304
Cincinnati, Ohio 45236
(5I3) 794-8777

DIPLOMATE AMERICAN BOARD OF
PSYCHIATRY AND NEUROLOGY

CHILD-ADOLESCENT-ADULT
PSYCHIATRY

Date: _____

Dear Patient:

Prior to your first appointment at our office we have sent you this packet. They have been divided up into three sections for your convenience.

SECTION I: Enclosed you will find material containing information about the procedures involved in a psychiatric evaluation as well as our office policies. Please read this carefully.

SECTION 2: The next set of materials are new patient information forms. Two of the forms are regarding basic information about you and a consent form for your insurance company. It is important that these forms be filled out completely and signed in order for us to efficiently file with your insurance company. There is also another consent form that allows Dr. Shapiro and his employees to receive and give information to your physician. All of these forms must be completed and returned to our office at your first appointment.

SECTION 3: These forms are questionnaires about you. These forms should also be filled out completely and returned to the office. Some of the questions may appear redundant but this is done to ensure a comprehensive and thorough evaluation to best meet your needs. (There are a total of four of these forms.)

Offices of Dr. Arnold. G. Shapiro

SECTION I:
Information for Patients

Arnold G. Shapiro, M.D. would like to provide you with information that will contribute to a successful treatment experience for your family. Please keep this information for future reference.

What Should I Expect?

The first two meetings are a comprehensive evaluation. By the end of the second meeting, you and Dr. Shapiro will be deciding if you will be treated in this office. The evaluation is a comprehensive psychiatric evaluation taking into consideration your medical, social, emotional and developmental needs. Initially, a licensed therapist will meet you to perform a one session evaluation. Dr. Shapiro and the therapist will then discuss and comprehensively evaluate all the information. This assists the doctor in his understanding and diagnosis for you. This also facilitates the development of the best possible treatment plan. The treatment plan will be presented to you in the second session with Dr. Shapiro.

Dr. Shapiro is a board-certified psychiatrist who specializes in children, and the therapists are licensed in their respective professions.

Two Session Patient Evaluation

The first session is held with you and the therapist for 1 (one) hour. Please bring the following:

The completed Patient Information Forms

The second session is held with yourself and Dr Shapiro. At the session, the diagnosis, treatment and recommendations are discussed. This session will last approximately 1 (one) hour.

Medication

If medication would be beneficial to the ongoing therapy, Dr. Shapiro will discuss the hoped-for benefits and possible side effects with you. If you agree, medication may be added to the treatment.

If medication is prescribed, Dr. Shapiro will monitor you to provide the type and dosage of medication to effectively treat your symptoms. You will have, at the minimum, monthly 10 to 15-minute office visits with Dr. Shapiro for medication evaluation and to receive any refills. More frequent or longer visits can be set up as indicated or as requested by you. You are encouraged to discuss your medication or any aspect of your treatment during the medication check visits with Dr. Shapiro or therapy visits. The information is discussed between Dr. Shapiro and the therapists.

Treatment

Dr. Shapiro and the staff develop a treatment plan, which is presented to you at the second session of the evaluation. Treatment plans vary depending on the presenting problems and clinical indicators necessary for the reduction or elimination of the symptoms. It is typical that a recommendation for weekly therapy be utilized as a part of the overall treatment plan. The duration is usually four to six months of weekly therapy. Once the situation has improved, frequency of appointments can be lessened to every other week and eventually once a month, until therapy ends. Therapy is provided by a licensed therapist under the supervision of Dr. Shapiro.

Location of Offices

One office is located at the Lookout Corporate Center on 1717 Dixie Highway, Ft. Wright, Kentucky. The other office is located at the Kenwood Commons at 8280 Montgomery Road, Cincinnati, Ohio.

Hours

The office can be reached by phone Monday through Thursday from 9 a.m. to 6 p.m. On Friday we are open from 9 am to 12 pm. Dr. Shapiro and the therapists can be reached after office hours by calling the office phone number and leaving a message on their individual voice mail.

Please reserve after hour calls for problems or questions that are urgent and cannot wait until the next appointment or the next business day.

Fees

The fees for Dr. Shapiro and his therapists are as follows:

$600 — Two session evaluation ($300 for the first meeting and $300 for the second meeting)
$200 — 1 (one) hour therapy sessions
$125 — 30-minute therapy sessions
$175 — 15-minute medication evaluation with Dr. Shapiro

Longer sessions with Dr. Shapiro can be scheduled as requested by you or as deemed necessary by Dr. Shapiro. Any sessions extending beyond these ranges will be charged proportionately. Time utilized for extended phone conversations with or about patients will be at the same rate as for a therapy session in the office.

Office Fee Policy

It is the office policy that all copayments are paid at the time of each session. If you have a deductible that needs to be met, you must pay the full session fee until the entire deductible is met.

We will try to determine what your copay will be before you come in for your first visit. This will be an estimate of your copay. It is important to remember that your insurance may not pay as much as we estimated, of course if the insurance company does not pay, you are responsible for the entire fee.

When it becomes necessary to use a collection agency to resolve a past due account, an additional 15% of your balance will be assessed to cover the costs of this action.

You must remember that you are ultimately responsible for your charges. Monthly statements from our office will be sent to keep you informed about your account.

Insurance

Most insurance companies reimburse 50% to 80% of the cost depending on the individual policy. No insurance plan covers "everything". There are always limitations and exclusions to coverage. Even with two or more insurance plans, there may be amounts or services not covered and for which the patient is responsible. Also, remember coverage is on the amount set by the insurance company. This set amount, usually referred to as the UCR, is usually lower than our current fee. This is a common coverage limitation. The patient portion of the payment is whatever the insurance does not cover. "Assignment" simply means the patient requests insurance payment be made directly to

the physician, This is not payment in full. The patient is responsible for the designated balance. Insurance filing requires a medical diagnosis for each procedure. Your plan may exclude certain diagnoses and, if so, you will be responsible for the charges. We recommend that you contact your employer or insurance company to verify the amount and extent of your coverage.

> Precertification: Some insurance require treatment plans or contact from your therapist and/or doctor to pre-certify further treatment. It is your responsibility to know this and keep track of the services you receive from the office and to alert your therapist and/or doctor and/or office manager at least two weeks prior to the time that the precertification service is needed. For example, if you need a precertification after five sessions it would be wise to discuss this policy with your therapist and/or doctor after session four to determine whether a precertification is warranted. If you do not do this and return for a sixth session, you will likely be financially responsible for that session.

We will file your insurance claims directly for office visits as a service we provide for you, however, the agreement of the insurance carrier to pay for medical care is a contract between you and the carrier and you should direct any questions or complaints regarding coverage to your insurance carrier. Our strongest recommendation is that if you choose to utilize insurance to pay for office visits, stay well informed regarding your policy. We will do what we can to assist you with this, but ultimately it is your responsibility.

Insurance payment made to the office will be credited to your account and any overpayment will be promptly refunded to the appropriate party.

Late Cancellation and No Shows

Patients are seen in the office by appointment only. It is the policy of the office to bill patients who cancel their appointment with less than 24 hours notice. While in treatment, all patients will be billed for scheduled sessions not canceled 24 hours prior to the. appointment. If we can schedule another patient in a canceled scheduled session, there will be no charge. However, it is difficult to schedule another patient at short notice. If you do not attend a scheduled appointment and have not given 24 hours notice, you will be responsible to pay for that missed appointment in full. This is because the therapist or Dr. Shapiro would have been seeing another patient during that time. If you give 24 hours notice you will not be responsible for the time because that would give us a. chance to schedule someone else in your place.

Please be aware that you will actually pay more, out of your pocket, if you do not attend the appointment than if you had attended. This situation exists because insurance companies will not reimburse for missed appointments, so you will pay the entire fee.

In the practice of psychiatry, advance notice of cancellation is especially important. For everyone's sake, attend scheduled appointments or cancel at least 24 hours before. Your consideration will be appreciated.

Your Billing Rights

This notice contains important information about your rights and our responsibilities under the Fair Credit Billing Act.

Please notify us in case of errors or questions regarding your bill.

If you think your bill is incorrect or you need additional information concerning a transaction on your bill, please write us in a separate letter at our address as soon as possible. We must hear from you no later than 60 days after sending you the first bill on which the error or problem appeared. You may telephone us but doing so will not preserve your right.

In your letter, give us your name, account number, and dollar amount of the suspected error. Describe the error and explain, if you can, why you believe there is an error. If you need more information, describe the item about which you are uncertain,

You do not have to pay any amount in question while we are investigating, but you are still obligated to pay the parts of your bill not in question. While we investigate your question, we cannot report you as delinquent or take any action to collect the amount you questioned.

Please call us at (859) 341-7453 or (513) 794-8777 if you have additional questions or concerns.

Arnold G. Shapiro, M.D.
Child Psychiatrist

NOTICE OF PRIVACY PRACTICES

Arnold G. Shapiro, M.D.

1717 Dixie Highway Suite 200
Lookout Corporate Building
Ft. Wright, Kentucky, 41011
(859)341-7453

8280 Montgomery Road Suite 304
Kenwood Commons Building
Cincinnati, Oh 45236
(513)794-8777

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY.

This notice takes effect on April 14, 2003 and remains in effect until we replace it.

This notice describes our Practice's policies, which extend to:

1) Any health care professional authorized to enter information into your chart (including physicians, LISW's, RN's, LPCC' s, etc)
2) All areas of the practice (front desk, administration, billing, collections, etc.)
3) All employees, staff and other personnel that work for or with our Practice
4) Our business associates (including a billing service, or facilities to which we refer patients), on-call physicians, and so on.

The Practice provides this notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA),

OUR THOUGHTS ABOUT YOUR PROTECTED HEALTH INFORMATION:

We understand that your medical information is personal to you and we are committed to protecting the information about you. As our patient, we create paper and electronic medical records about your health, our care for you and the services and/or items we provide to you as our patient. We need this record to provide for your care and to comply with certain legal requirements.

PATIENT RIGHTS

THIS SECTION DESCRIBES YOUR RIGHTS AND THE OBLIGATIONS OF THIS PRACTICE REGARDING THE USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION.

You have the following right regarding medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records but does not include psychotherapy notes. Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodian) may also be disclosed.

To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer, ask the front desk person for the name of the Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. The person conducting the interview will not be the person who denied your request. We will comply with the outcome and recommendations from that review.

Right to Amend: If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the Practice maintains your medical record.

To request an amendment, your request must be submitted in writing, along with your intended amendment and a reason that supports your request to amend. The amendment must be dated and signed by you and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1) Was not created by us, unless the person or entity that created the information is no longer available to make amendment.
2) Is not part of the medical information kept by or for the Practice.
3) Is not part of the information which you would be permitted to inspect and copy; or
4) Is inaccurate and incomplete

Worker's Compensation: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: Law or public policy may require us to disclose information about you for public health activities. These activities generally include the following:

1) To prevent or control disease, injury or disability.
2) To report births or deaths.
3) To report child abuse or neglect.
4) To report reactions to medications or problems with products.
5) To notify people of recalls of products they may be using.
6) To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
7) To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities: We may disclose medical information to a local, state or federal agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. The activities are necessary for the payor, the government and other regulatory agencies to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court of administrative order. This is particularly true if you make your health an issue. We may disclose medical information about you in response to subpoena, discovery request or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so that you may obtain an order protecting the information requested if you so desire. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

1) In response to a court order, subpoena, warrant, summons or similar process.
2) To identify or locate a suspect, fugitive, material witness or missing person.
3) About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement.
4) About a death we believe may be the result of criminal conduct and
5) About criminal conduct at the Practice.

Right to an Accounting of Disclosures: Yon have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others.

To request this list, you must submit your request in writing. Your request must state a time period no longer than six years back and may not include dates before April 14, 2003 (or actual implementation date of the HIPAA Privacy Regulations). Your request should indicate in what form you want the list (for example, on paper, or electronically). We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care (a family member or friend). For example, you could ask that we not disclose information about a particular treatment you received.

We are not required to agree to your request, and we may not be able to comply with your request. If we do agree; we will comply with your request except that we shall not comply, even with a written request, if the information is exempted from the consent requirements or we are otherwise required to disclose the information by law.

To request restrictions, you must make your request in writing. In your request, you must indicate the following:

1) What information you want to limit.
2) Whether you want to limit our use, disclosure or both, and.
3) To whom you want the limits to apply, (e.g., disclosures to your children, parents, spouse, etc.)

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail, that we not leave voice mail or e-mail, or the like.

To request confidential communications, you must make your request in writing. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish us to contact you.

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Patient's Name: _____

Patient, Patent or Guardian's Signature: _____

Relationship to Patient: _____

Date:_____

Behavioral Health/Primary Care Physician/Patient care communication form

Patient name:_____ Date of birth: _____

Primary Care
Physician: _____ Address _____

Behavioral health clinician: Dr. Arnold Shapiro 1717 Dixie Hwy Suite #200 Ft. Wright, KY 41011

AUTHORIZATION TO DISCLOSE INFORMATION

I understand that records or information about my mental health and drug abuse treatment and counseling are confidential; they are protected by applicable state and federal laws and cannot be re-disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that any information about me concerning AIDS, HIV and AIDS related complex and the performance of any tests, counseling and the results of treatment thereof cannot be released without my authorization. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire 60 days from the date signed.

To patient: Please check option below: I, _____

A. _____DO authorize any information on my care to be shared between the providers listed above to facilitate my treatment.

B. _____Do authorize information on my care with the following limitations (circle any)

Medications only Information to primary care only

Other _____

C. _____DO NOT authorize any information on my care to be shared between my behavioral health clinician and my primary care physician, names above, for the purpose of facilitating my treatment.

_____ _____

Signature of Parent/Guardian Date

To be completed by Behavioral Health Clinician:

Diagnosis:

Treatment Plan:

Current Medications:

Comments:

Behavioral Heath Clinician Signature: _____

ARNOLD G. SHAPIRO, M.D.

CHILD, ADOLESCENT & FAMILY PSYCHIATRY

Real hope, real help, for children & adolescents

EFFECTIVE TREATMENT FOR CHILDHOOD DISORDERS & CONCERNS:

- ADHD
- Depression
- Oppositional, acting our & destructive behavior
- Fears, panic & separation anxiety
- Tourerre's syndrome
- Obsessive-Compulsive behavior
- Neurological disorders
- Adjustment problems: school & home
- Behavior & discipline conerns
- Issues related to remarriage, divorce, adoption, sibling

CONFIDENTIAL HELP FOR YOUNG PEOPLE & THEIR FAMILIES:

- Individual, marital & family psychotherapy
- Play therapy for young children
- Group psychotherapy
- Medication evaluation & titration
- Crisis intervention
- Forensic evaluation & consultation

OFFERING COMFORT & CONVENIENCE:

- Morning, evening & weekend hours
- Most insurance plans accepted
- Visa & MasterCard honored
- 24-hour on call for emergencies

ARNOLD G. SHAPIRO, MD
Specialist in Child Psychiatry
Board Certified• American Board of Psychiatry 6-Neurology
Member: Academy of Child Psychiatry American Psychiatric Association, Ohio State Medical Association, Kentucky State Medical Assocation, Academy of Medicine (Cincinnati),
ADD Coucil-Board Member,
CHADD Advisory Board Member
Diplomate: National Board of Medical Examiners
MD: University of Rochester School of Medicine; BA: Magna CUM Laude, Ashington University
Author/Lecturer/Consultant

8280 MONTGOMERY ROAD.
CINCINNATI. OH 45236
(513) 794-8777
FAX (513) 794-8779

Cancellation Policy

Please help us serve you better by keeping scheduled appointments. In the event you are unable to keep your appointment we request, at minimum, a 24-hour notice. Due to our limited availability, appointments not cancelled within 24 hours will be considered a "No Show/Missed Appointment." In the event you miss three appointments in our office with your therapist, you will no longer be allowed to schedule any future therapy appointments. In the event you miss three appointments in our office with Dr. Shapiro, you will no longer be able to remain under our care. You will then need to find a new doctor and a new therapist. A copy of your records will be available for your new doctor once a release is signed in our office. Dr. Shapiro will only then be available for emergencies for 30 days after your last missed appointment. This policy will be strictly enforced. We sincerely hope you find a way to keep all of your scheduled appointments, so this won't ever affect you.

I understand this policy and agree to this policy.

Patient Name: _____

Parent/Guardian Signature: _____

Date Signed: _____

SECTION 2:

Arnold G. Shapiro, M.D.

1717 Dixie Highway, Suite 200
Lookout Corporate Building
Ft. Wright, Kentucky 41011
859-341-7453

8280 Montgomery Road, Suite 304
Kenwood Commons
Cincinnati, Ohio 45236
513-794-8777

New Patient Information

Welcome To Our Office

Date: _____

Patient's Name (please print)	Goes By	Social Security Number	Birth Date	Age

Street Address	City and State	Zip Code	Home Phone #

Patient's Employer	Occupation (Indicate if student)	Business Phone #

Employer's Street Address	City and State	Zip Code

Drug Allergies, If Any

Spouse Name	Social Security Number	Birth Date

Spouse Employer	Occupation	Business Phone #

Employer's Street Address	City and State	Zip Code

**Please Read: All charges are due at the time of services. Whoever seeks treatment in the office is ultimately responsible for payments.*

Person Responsible for Payment	Street Address, City and State	Zip Code	Home Phone #

Name of Insurance Company and Policy Holder Name	Date of Birth	ID #	Group #

Second Insurance Company and Policy Holder Name and Date of Birth	ID#	Group #

PATIENT'S AUTHORIZATION TO RELEASE
MEDICAL INFORMATION
AND
CLAIM PAYMENT AUTHORIZATION

I hereby authorize the physician(s) whose name(s) appear on this statement to release any information acquired in the course of examination, if needed, to the insurance company only. Also, to allow a photocopy of my signature to be used for the insurance company.

Signature of Patient: _____

Date: _____

I hereby claim health insurance benefits due me for services rendered by the physician(s) and associate(s) and authorize and direct my insurer to issue payment check(s) directly to the physician(s) and associate(s) named below.
Regardless of my insurance benefits, if any, 1 understand I am financially responsible for the fees for services rendered.

Date: _____

_____
Signature of Patient, Parent or Guardian if minor

_____Arnold G. Shapiro, MD_____
Physician's Name

SECTION 3: FORM 1

ARNOLD G. SHAPIRO, MD

Person filling out form: _____
Patient Name: _____ Date: _____

MOOD DISORDERS

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

1. _____ Sad often.
Examples: _____
_____

2. _____ Decreased interest in people or activities.
Examples: _____
_____

3. _____ Change in appetite (increased or decreased).
Examples: _____
_____

4. _____ Change in sleep pattern. Insomnia or hypersomnia (sleeping more that usual).
Examples: _____
_____

5. _____ Low energy or tiredness.
Examples: _____
_____

6. _____ Low self-esteem.
Examples: _____
_____

7. _____ Poor concentration.
Examples: _____
_____

8. _____ More trouble making decisions.
Examples: _____
_____

9. _____ Feelings of hopelessness.
Examples: _____
_____

10. _____ Talk of death or suicide.
Examples: _____
_____

11. _____ Feelings of worthlessness.
Examples: _____
_____

12. _____ Worries often.
Examples: _____
_____

SECTION 3: FORM 2

ARNOLD G. SHAPIRO, MD

Person filling out form: _____
Patient Name: _____ Date: _____

OPPOSITIONAL DEFIANT DISORDER

Please write: NO or YES on the lines below next to the behaviors. Also list specific examples of each.
YES = OFTEN OR VERY OFTEN; QUITE A BIT OR VERY INFREQUENT
NO = NEVER OR SELDOM

1. _____ Often loses temper.
Examples: _____
_____

2. _____ Often argues with adults.
Examples: _____
_____

3. _____ Often actively defies or refuses adult requests or rules (e.g. refuses to do chores at home).
Examples: _____
_____

4. _____ Often deliberately does things that annoy other people (e.g. grabs other children's hats).
Examples: _____
_____

5. _____ Often blames other for his/her own mistakes or misbehavior.
Examples: _____
_____

6. _____ Is often touchy or easily annoyed by others.
Examples: _____
_____

7. _____ Is often angry or resentful.
Examples: _____
_____

8. _____ Is often spiteful and vindictive.
Examples: _____
_____

How many months have these behaviors gone on (continuously)? _____

If known, at what age do you think this started? _____