Jack L. Koch Jr., MD, PLLC
Board Certified in Child, Adolescent, & Adult Psychiatry
1507 16th Avenue S., Nashville, TN 37212
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Patient Agreement

Patient Care

Thank you for choosing me to provide your psychiatric care. I strive to provide outpatient mental health services; including evaluation, diagnosis, education, and treatment; for children, adolescents, and adults. My treatment approach is individualized for each patient in order to address psychoeducational, psychotherapeutic, and/or pharmacologic management needs.

Although I do not have an inpatient practice, should you require admission to a hospital or residential setting, I will assist you in making appropriate arrangements, readily communicate with inpatient providers, and resume outpatient treatment at the time of discharge.

Appointments

The nature of outpatient psychiatric care requires an initial evaluation and subsequent follow-up visits as scheduled appointments. Follow up appointments are typically 25, 45, or 60 minutes in duration and a full business day's (24 hours Monday through Friday) notice of cancellation is required. Appointments that are missed or are canceled less than one business day in advance will be charged the full appointment charge.

If you anticipate not being able to make it to your scheduled appointment, please notify the office with as much advanced notice as possible. Please note: appointments scheduled and not kept will be billed to you and insurance companies will not reimburse for any portion of missed appointments.

If you have a regularly scheduled appointment and must cancel, I will assume that you intend to keep your next regularly scheduled appointment unless you notify the office otherwise.

Fees & Insurance

Although I am not a participating provider for any insurance networks, I am happy to provide a statement of service that you may file with your insurance provider. Please remember that your insurance is to reimburse you directly for the services provided. The fee for you or your child's initial evaluation is $400 and is due at the time of service. Payment may be made by cash, check, Venmo, or credit card (Visa or Mastercard).

Statements are generally sent out at the end of each week. If you will be submitting the visits to your insurance provider for reimbursement, please let the office know in order to make sure the statements will contain the information needed to submit the claim. Insurance forms are generally available from your health insurance carrier or employer. An option to potentially simplify your filing for reimbursement is to use the Reimbursify app.

Prescriptions

New and refill prescriptions should be obtained at the time of regularly scheduled visit. If you do require a refill between sessions, please check with your pharmacy to see if refills have already been authorized. If no refills are available, please call the office Monday through Friday from 9:00am to 4:00pm. As Dr. Koch is not always in the office to provide refills, please know that it may be three or four days before the requested prescriptions are available. The office will notify you when the prescription is ready and there is a $10 charge for refills provided outside of regularly scheduled follow-up visits.

As some pharmacies fax automated refill requests, please request your pharmacy disable these automated reminders. In order to avoid inadvertent charges for refill requests, faxed prescription refill authorizations received from pharmacies are generally ignored unless the office has received advanced notification from you that the refill is, indeed, needed.

Emergencies

In the event of an emergency (a situation which requiring immediate attention due to concerns of for an imminent danger to self or others), please call 911 or go to your local emergency room/department. Please ask the physician to contact me directly as appropriate. NOTE: after 4pm Monday through Friday and on weekends, there are no staff to accept telephone calls. Messages can be left on my emergency voicemail that will attempt to page me directly. If for any reason during an emergency situation you are unable to reach me, you should go directly to the nearest emergency room. Hospitals providing emergency psychiatric assessment:

Vanderbilt Psychiatric Hospital (Psychiatric Assessment Service): (615) 327-7000; Parthenon Pavilion (Options): (615) 342-1400; Rolling Hills Hospital (Respond): (800) 832-0388.

Non-urgent Communication

If you need to speak with me between appointment visits, please leave a message with the office at (615) 515-7775. As I may not be immediately available, please leave both daytime and nighttime numbers so that I may best return your call. I will make every effort to return calls on the same day that messages are left.

Confidentiality

With your consent, the office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment, and health care operations. Protected health information is the information we create and obtain in providing our services to you. Such information may include documenting symptoms, examination and test results, diagnoses, treatment, and applying for future care or treatment. It also includes billing documents for those services.

Examples of uses of your health information for treatment purposes are:
Staff obtains treatment information about you and records it in a health record. During the course of your treatment, the doctor may determine that you need an EKG, medical procedure, laboratory test, or emergency evaluation. He/she will share information with the doctor, or assistant, in order to get your tests completed or to permit emergency care in the case of an emergency assessment.

Examples of uses of your health information for payment purposes:
Submission of information for payment to your health insurance company. The health insurance company or business associate helping us obtains payment requests information from us regarding your medical care given. We will provide information to them about you and the care given.

Examples of uses of your health information for health care operations:
We may obtain services from business associates such as quality assessment, quality improvement, outcome evaluation, protocol and clinical guidelines development, training programs, credentialing, medical review, legal services, billing services, mailing services, and insurance.

Additional information is available on the website:drjackkoch.com and in the office policies.

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I hereby authorize Jack L. Koch Jr., M.D. to provide treatment for my child and agree to assume full responsibility for fees for these services.

Should it become necessary, I authorize Jack L. Koch Jr., M.D. to release and exchange in verbal and/or written form any information necessary for the payment of fees, and/or the provision of my medical care. This may include information related to alcohol or substance abuse.

By signing this form, you hereby agree to pay your account within 45 days following the date of the payment invoice. Should you fail to pay your account in a timely manner, you will also pay on demand late charges and any amount incurred in collecting, enforcing, or protecting the Provider's rights under this agreement. These expenses will bear interest from the date payment is due until paid in full at the interest rate permissible by Tennessee law in effect at the signing of this document. This amount may include, but is not limited to attorneys' fees, court costs, and other legal expenses incurred at all stages of collection.

If the person responsible for payment will not be present at the time of the initial visit, please have them provide credit card information to my office manager prior to the initial evaluation date.

I have read this form in full and have received a copy of Jack L. Koch Jr., M.D.'s office policy. I agree to assume full responsibility for the fees for the services provided.

Signature:________________________________ Date:_____________

Patient (or Parent if patient is minor)

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Good Faith Estimate

Provider Name: Jack L. Koch Jr., M.D.	**Provider License:** MD27427
Provider Address: 1507 16th Avenue S., Nashville, TN 37212	
Provider Phone: (615) 515-7775	
Provider Tax ID: 20-4875847	Provider NPI: 1114923737

Patient Name:	
Parent Name (if Patient is minor):	
Patient Address:	
Patient Phone:	**Patient e-mail:**

You are entitled to receive this "Good Faith Estimate" of the estimated charges for psychotherapy services provided to you. While it is not possible for a psychotherapist to know, in advance, how many psychotherapy sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychotherapy sessions you attend and your individual circumstances. This estimate is not a contract and does not obligate you to obtain any services from the providers listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychotherapy visits. The number of visits that are appropriate in your case and the estimated cost for those services is unknown and based on your needs, preferences, progress made in therapy and what you agree to in consultation with your therapist. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

Depending upon you/your child's treatment needs, visits may range from weekly, to biweekly, to monthly, or once every three months. Your ultimate total fee for treatment services will be the cost of the initial psychiatric evaluation plus the remaining number of sessions in the time period multiplied by the session fee.

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Visit Type	**Fee**
Initial Psychiatric Evaluation	$400
25 minute sessions	$200
45 minute sessions	$245
60 minute sessions	$295

	Initial Visit Plus:					
Length of Treatment	**4-60 min. sessions/ month**	**4-45 min. sessions/ month**	**4-25 min. sessions/ month**	**2-60 min sessions/ month**	**2-45 min. sessions/ month**	**2-25 min. sessions/ month**
1 month	$1,285	$1,135	$1,000	$695	$645	$600
3 months	$3,645	$3,095	$2,600	$1,875	$1,625	$1,400
6 months	$7,185	$6,035	$5,000	$3,645	$3,095	$2,600
9 months	$10,725	$8.975	$7,400	$5,415	$4,565	$3,800
1 year	$14,265	$11,915	$9,800	$7,185	$6,035	$5,400