Best Practices Psychiatric & Mental Health PLLC.
Dr. Salema Coaxum, DNP, APRN, PMHNP-BC
Mailing: 3495 Lakeside Dr., PMB 273, Reno, NV 89509
Practice: 123 W. Nye Lane, Carson City, NV 89706
Phone: (775) 224-7099

Policies & Procedures

Client Rights:

- Each client has the right to be treated fairly, with dignity and respect, regardless of race, religion, gender, ethnicity, age, disability and/or sexual orientation.
- Each client has the right to have their treatment and patient information kept private in accordance with Health Insurance Portability and Accountability Act (HIPPA) privacy rules.
- Each client has the right to participate in their individualized plan of care.

Client Responsibilities:

- To provide information pertinent to your care.
- To treat the provider with the same dignity and respect extended to you.
- To refrain from any actions that could endanger the lives of the provider, other treating professionals and/or other clients.
- To keep your scheduled appointments.
- To adhere to the controlled substance medication agreement.
- To never share or sell medication.
- To call 911 or seek medical attention if experiencing suicidal or homicidal thoughts

Consent for Treatment:

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Salema Coaxum, DNP, APRN, PMHNP-BC. By giving consent, the individual is consenting to psychiatric and mental health services provided by the provider. The individual understands that his or her rights, including confidentiality or participation in services, will be observed in accordance with state and federal laws and regulations. If the individual signing the consent is a Representative/Parent/Guardian, the individual must show documentation that he/she can act in this capacity on behalf of the individual.
The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

- It is the client's responsibility to verify that his or her insurance covers the cost of treatment and is responsible for payment for any services not covered under his or her healthcare plan. The client or Parent/Guardian is responsible for payment of all services not paid by insurance.

Cancellations and Missed Appointments:

It is important that clients arrive for all scheduled appointments or cancel the appointment 24 hours in advance. You may cancel your scheduled appointment by calling the office at (775) 224-7099. If you are late for your appointment, the appointment will end as scheduled and you will be charged the full amount of your visit. Multiple cancellations will lead to termination of services, and once a client has "missed" 3 appointments without rescheduling, the client will be discharged from treatment

Financial Policies:

Payment for service is due at the time service is rendered. I accept Medicare, Medicaid, Private-Pay (Pay Pal), and Private Insurance.

Fee Schedule for Private Pay:

- $150.00 Psychiatric Diagnostic Evaluation (60 minutes)
- $100.00 Psychiatric Follow-up (30 minutes)
- $150.00 Psychotherapy Initial Evaluation (60 minutes)
- $125.00 Psychotherapy (45 minutes)

Statement Regarding Ethics, Client Welfare & Safety:

Best Practices Psychiatric & Mental Health follows a zero-tolerance weapons policy. No weapon of any kind is permitted on the premises, including guns, explosives, ammunition, knives, swords, razor blades, pepper spray, garrotes, or anything that could be harmful to yourself or others. I reserve the right to contact law enforcement officials and/or terminate treatment with any client who violates this weapons policy.

By signing below, you acknowledge that you understand your rights and responsibilities and that you give your consent for care and treatment.

_____ _____

Client Name (Please Print) Date

_____

Client Signature

_____ _____

Parent's or Legal Guardian's Name (Please Print) Date

_____

Parent's or Legal Guardian's Signature

The signature of the Provider below indicates that s/he has discussed this form with you and has answered any questions you have regarding this information.

_____ _____

Salema Coaxum, DNP, APRN, PMHNP-BC Date