Total Wellness Mental Health Services

P:757-663-7547 F:757-802-3897 E: patientforms@totalwellnessmhs.com

Total Wellness
MENTAL HEALTH SERVICES

Preferred Provider: _____

New Patient Information

Please complete information as it appears on your insurance card and photo ID.

First Name: _____ Last Name: _____ DOB: _____

Preferred Name: _____ SSN: ___ - ___ - ____ Gender: ☐ Male ☐ Female

Sexual Orientation: _____ Gender Identity: ☐ Male ☐ Female ☐ FTM ☐ MTF ☐ Non-binary

Preferred pronoun: _____ Ethnicity: _____ Race: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary phone number: _____ Alternate phone number: _____

Physical Address: _____

City: _____ State: _____ Zip code: _____

Email address: _____

All clients will receive an automated text and email for appointment reminders.

Responsible Party or Parent/Guardian Information:

(If you are OVER THE AGE OF 18, you are YOUR OWN responsible party.)

Please note if the client is under the age of 18, the responsible party must sign all paperwork.

Name: _____ Relationship to patient: _____

SSN: ___ - ___ - ____ Physical Address: _____

City: _____ State: _____ Zip code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Insurance Information:

Primary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Relationship to Patient: _____ Subscriber SSN: ___ - ___ - ____

Secondary Insurance: _____ ID #: _____ Group #: _____

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Relationship to Patient: _____ Subscriber SSN: ___ - ___ - ____

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PAST MEDICAL HISTORY

What medications have you trialed? List your response and duration of time used:
(ex. Zoloft - Ineffective; felt worse; 90 days)

Medication 1: _____

_____

Medication 2: _____

_____

Medication 3: _____

_____

Medication 4: _____

_____

Medication 5: _____

_____

Medication 6: _____

_____

Do you now or have you ever had the following (check all that apply):

☐ **Diabetes** ☐ **Heart Murmur** ☐ **High Cholesterol** ☐ **Colitis** ☐ **Hypothyroidism**
☐ **Seizures/epilepsy** ☐ **Crohn's Disease** ☐ **High Blood Pressure** ☐ **Pneumonia** ☐ **Stroke**
☐ **Pulmonary embolism** ☐ **Anemia** ☐ **Concussions** ☐ **Traumatic Brain Injury (TBI)**
☐ **Sports injuries** ☐ **Psoriasis** ☐ **Asthma** ☐ **Jaundice** ☐ **Emphysema** ☐ **COPD**
☐ **Hepatitis** ☐ **Cancer** ☐ **Cataracts** ☐ **Leukemia**

Any other medical and/or surgical history? Please list history and dates: _____

_____

_____

_____

_____

_____

_____

_____

_____

CURRENT MEDICATIONS (include nutritional/herbal supplements and over-the-counter medications):

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Name of Medication & Approx Start Date: ______________________

Dosage: __________ **Frequency:** __________ **Reason Prescribed:** __________

Please list any medication or food allergies: ______________________

____

____

____

Please provide pharmacy of choice and include address and phone number: ______________________

____

____

____

Office Policy and Procedures

Privacy and Release of Information

Our practice values and upholds the importance of your confidentiality. In addition to your rights as a patient, our practice has duties to protect your confidential information and inform you of changes for protection measures. We are required by law to maintain the privacy of confidential information and provide you with notice of our legal duties and privacy practices with respect to such information, we are required to abide by the terms of this notice currently in effect.

There are, however, certain situations in which we must, by law, communicate your confidential information. Here is a list of those circumstances:

- We have reason to believe you are a danger to yourself or another person(s).
- We become aware of abuse to a child, elder or developmentally disabled person.
- We are under court order to release information.
- Subpoena of treatment records by an attorney.
- If you are applying for your health insurance benefits, we may be required by law to provide information to your health plan, including some or all your patient chart, for them to approve reimbursement. By signing the "acknowledgment of policies and procedures" you consent to release that information to your health plan.
- If you are party to child custody litigation at any time in the future, the court may order release of information about your treatment here.
- In some instances, as provided by the state law of Virginia, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment.

Initial:_____

Provider Information:

I consent to care by a mental health professional as listed:

Kanisha Belt, PMHNP-BC

Initial:_____

Disclosure and Confidentiality

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The definition of a health insurance plan does not include life insurance companies, automobile insurance companies or workers' compensation carriers. These are not covered under HIPAA. If you would like information submitted to one of these companies, an authorization will be required, unless it is already mandated by state or federal law. The following routine situations necessitate the use of your information:

For treatment-We may use information about you in order to provide you with proper medical treatment or services. Treatment is when we provide, coordinate or manage your healthcare and other services related to your healthcare. An example of treatment is when we consult with another healthcare provider such as your primary care provider.

For Healthcare and Medication Authorizations-We may use and disclose information about you so that the treatment and services you receive can be reimbursed from an insurance company. For example, we may give your health insurance plan information about services you received at the practice, so your health insurance can reimburse you for the services we have provided. We may also tell your heatlh insurance plan about a treatment you are going to receive in order to obtain approval for certain medication we may prescribe.

For Healthcare Operations-We may use and share information about you for administrative functions necessary to run the practice and promote quality care. We may share information with business associates who provide services necessary to run the practice, such as transcription companies or billing services. Also, we may permit other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care-This practice may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. Overall, it is our mission to honor confidentiality of our patients with utmost regard. Information disclosed will be directly relevant to such person's involvement with your care. In emergencies or other situations in which you are unable to indicate your reference, we may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

Initial: _____

Special Circumstances in Release of Private Information

The following special circumstances necessitate the use of your information:

As Required by Law-We will disclose information about you when required to do so by federal, state or local law. For example, we may release information about you in response to a valid court subpoena.

Health Oversight Activities-We may disclose information to a health oversight agency for activities authorized by law. For example, these oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs and compliance of civil rights laws.

For Judicial or Administrative Proceedings-If you are involved in a court proceeding, and a request is made for information about the professional services that you have received within our practice and the records thereof, such information may be privileged under state law. We will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena, which requires the provision of such information, which you have been properly notified. In response, you have not opposed the court subpoena within the legally specified format and time frame, or in the instance of issuance of a court order compelling us to provide Protected Health information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

To Avert Serious Threat to Health or Safety-We may disclose your confidential mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of another individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threats of harming another individual may be reported to appropriate authorities.

Workers' Compensation-If you file a workers' compensation claim with certain exceptions, we must make injury in the opinion of the VA Dept. of Labor and Industries upon request.

Public Health Risks-We may disclose information about you for public health activities. These activities generally include but are not limited to the following:

- To prevent or control disease, injury or disability
- To report child abuse or neglect
- To report adult or domestic abuse
- To report reactions to medications or problems with products
- To notify people of recalls of products they may be using
- 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
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence

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

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness, or missing person
- If you are suspected to be a victim of a crime, generally with your permission
- About a death we believe may be the result of criminal conduct
- About criminal conduct at the hospital
- In emergency circumstances involving a crime; the location of the crime or victims, or the identity, description, or location of the person who committed the crime

Other uses and disclosures of information not covered by this notice or the laws that apply to our practice will be made only with your written permission. If you provide this practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that we are required to retain our records of the care that we provided to you.

Initial:_____

Patient Records

An electronic record is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to medical providers you designate at no cost or may be picked up in person at your expense for a fee of $20 plus $0.50 per pages 1-50 and $0.25 per pages 51 and up, according to charges stipulated by the state law of Virginia. Under certain circumstances where seeing the record may put a patient or other person at risk, we may redact certain information in the record and/or require the record in consultation with another provider. You may receive an accounting of non-routine uses and disclosures of you record.

Initial:_____

Concerns for Safety

If as a patient, you are deemed a safety concern for self/others, or are assessed during evaluation to have declined physically and emotionally to the point that self-care is an issue, it is our legal obligation to inform mental health deputies or officials for further action which may include detainment or acute psychiatric hospitalization. In such events as noted above, your records will be released to officials and that facility.

Initial:_____

Right to Terminate Treatment

In certain rare circumstances, our office may reserve the right to terminate your treatment at Total Wellness Mental Health Services, LLC. We will immediately notify you if this occurs. In the event of misuse of prescriptions or in the case that your treatment is no longer seen as therapeutic, such that our options are maximized and further rapport and agreement in your care is compromised, then we may terminate our relationship. We will do your best to recommend further referrals. We also reserve the right to terminate treatment related to repeat missed appointments.

Initial:_____

Payment Policy

As a patient, you must be aware of current established payment policies. Prior to you established visits, please thoroughly read and acknowledge our established payment guidelines as outlined below. The payment for each visit is due at the time of services. In order to communicate with your insurance company to verify treatments in the event that you have submitted a receipt for reimbursement or medication authorizations, we must have a copy of your insurance card on file. It is the patient's responsibility to resubmit insurance cards should your coverage change. Not all services rendered covered by insurance contracts, and while we agree to file insurance for you, and the patient remains responsible for any charges not covered by insurance. It is further understood and agreed that if this account or a debt owed to us is referred to a collection agency or attorney, you agree to pay in addition to the balance on the account all collection fees in the amount of 35% of the total unpaid balance due, plus court costs and filing fees incurred by you. You agree to pay aforesaid costs of collection whether or not a suit is filed.

Initial:_____

Fee List:

$175 New Patient Consultation for CBD/THC-A oil (60 mins)

$100 CBD/THC-A oil Recertification (60 mins)

$200 New Patient Medication Evaluation (60 mins)

$90 Medication Follow-up (30 mins)

$80 NO CALL NO SHOW

$50 LATE CANCELLATION (less than 24 hours)

Other Associated Fees:

Initial:_____

$100 Emotional Support Animal Letter (annual renewal)

$100 Court/Probation/Parole letter

$150 Disability or Workers' Compensation Paperwork

$60 FMLA Paperwork for each occurrence

Miscellaneous paperwork pricing subject to time of completion

Payment Responsibilities

Payment for psychiatric services is due in full at the time of service. You will be responsible for full amount of payment at the time of your appointment.

Acknowledgment of Policies and Procedures and Consent for Treatment

Total Wellness Mental Health Services, LLC policies may be subject to change, of which you will be informed at your next visit.

I, as the patient or patient's legal representative, hereby grant permission for the providers at Total Wellness Mental Health Services, LLC to perform such examinations, medical and therapeutic procedures as may be professionally deemed necessary and to communicate about them via telephone, mail, facsimile and e-mail for the patient's diagnosis, treatment and payment.

I am aware that healthcare is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. Hereby, I consent to be treated with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable.

I understand and agree to the policies and procedures of Total Wellness Mental Health Services, LLC and consent for treatment:

Patient Signature:_____ Date:_____

Printed Name:_____

Total Wellness Mental Health Services, LLC will file claims for services to your in-network insurance as a courtesy. The contract, however, is between you and your carrier. Therefore, please note the following patient payment policy changes:

- The patient is responsible for providing accurate insurance information to our office. We will verify your insurance eligibility (to the best of our ability) prior to your visits.

- Payment is due at the time of service. This includes but is not limited to copays, coinsurance, and deductibles.

- Any rejection of claims from an insurance carrier regarding eligibility, coordination of benefits (if you have more than one insurance) or the insurance company's misapplication of benefits is the responsibility of the patient to resolve.

- Patients may receive a bill from our office regarding any balances that have not been paid by insurance for the above reasons, as the account will be placed in a self-pay status. Our office will give the patient ample time (60 days) to resolve issues with their carrier. If the patient carries a balance for 90 days without resolution, payment, or payment agreement that has been adhered to, the account will be turned over to a collection agency and the ability to receive services from our office will be halted.

I have read the above patient payment policy and agree to the terms set forth by Total Wellness Mental Health Services.

Initial:_____

Informed Consent For Telemedicine Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or sub-specialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to tele-medicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. Kanisha Belt, PMHNP-BC has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Kanisha Belt, PMHNP-BC of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Virginia and will be present in the state of Virginia during all telehealth encounters with Kanisha Belt, PMHNP-BC.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

I hereby authorize Kanisha Belt, PMHNP-BC to use telemedicine in the course of my diagnosis and treatment.

Patient Signature: _____ Date: _____

Patient Printed Name: _____

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Patient Name:

Address:

Home Phone:

Cell Phone:

DOB:

Name on Card:

Card Type:

Card Number:

Expiration Date:

CVV:

Zip Code:

Please be advised that we do require a notice of at least 1 business day on all appointment cancellations. You will be charged $80 for a No Call No Show and $50 for a late cancellation (less than 24 hours).

Your signature below authorizes Total Wellness Mental Health Services to debit your account any balances, copays, deductibles, coinsurances, and/or other amounts indicated on or after the date indicated on this agreement.

Any amounts owed are due in full the day of your appointment prior to services being rendered.

I hereby certify that I have read and received a copy of this statement and agree to its terms and conditions.

Signature:_____ **Date:** _____

Printed Name:_____

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