Olive Branch
Integrative Mental Wellness

Morgan Webb, MSN, PMHNP-BC
31 Gooden Ave Dover, DE 19904
P: (302) 480-9422 F: (833) 974-3996
Frontdesk@obintegrative.com

New Patient Registration Form

Last Name: _____First Name: _____ MI: _____

DOB: _____ Social Security Number: _____

Gender: _____ Marital Status: _____ Email address: _____

Home Phone: _____ Cell/Mobile: _____

Home (Billing) Address: _____ City: _____

State: _____ Zip: _____

Emergency Contact Name: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Based on government regulations, we are required to gather the following information:

Preferred Language: _____ Ethnicity: Hispanic/Latino Non-Hispanic/Latino

Race: American Indian or Alaskan Native / Asian / Black or African American / Caucasian / Other

Current Insurance Information

(We collect this for potential superbill purposes only)

Primary Insurance Company: _____ Co-Pay Amount: _____

Insurance ID/ Policy #: _____Group #: _____

Insurance Holder Name: _____

Insurance holder DOB: _____

Do You have out of network benefits? _____

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Medical History Information

Patient Name: _____ DOB: _____Age:_____

Gender: _____

Known Drug Allergies: _____

Food Allergies: _____ Height: _____Weight: _____

Date of last physical: _____ Date of last menses: _____

Surgeries: _____

Medical Hospitalizations: _____

Have you ever been diagnosed with the following?

	YES	NO	EXPLANATION
Cardiac/Heart (HTN, CAD, Heart Attack, POTTS, Palpitations, Stents)			
Respiratory/Lungs			
Neurological (Stroke, MS, Memory Changes)			
Stomach/GI			
Bladder/Kidneys			
Endocrine/Thyroid			
Musculoskeletal (Pain, Arthritis, Joint Problems)			
Other (Sleep Apnea, Rheumatology, Cancer)			

My PCP: _____

Additional Care Team Members: _____

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Mental Health History Information

Have you ever been diagnosed with the following from a medical professional?

	YES	**NO**	**EXPLANATION (Year, Name of medical professional, treatments)**
Depression			
Anxiety			
Bipolar Disorder			
ADHD			
Schizophrenia			
Personality Disorder			
PTSD			
Eating Disorder			
Sleep Disorder			
Other			

Reason for mental health referral:

_____

I have been hospitalized in the past for my mental health (circle): Yes / No

My Therapist (If applicable):_____

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Medication List

Please list both prescriptions, over the counter, and any supplements you currently take.

Pharmacy: _____Allergies to Medications: _____

Medication Name	Dose/Strength	Times Per Day

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Family History Information

Please complete by writing in each box the specific condition each family member is diagnosed with.

	Mother	Father	Sister	Brother	Grandmother	Grandfather
Cardiac/Heart Disease/ HTN						
Neurological						
Endocrine (thyroid)						
Respiratory						
Mental Illness						
Other						

***Known family history of suicide? (circle)** YES or NO

SOCIAL HISTORY

Do you smoke? YES or NO Number of cigarettes a day:_____

Do you drink alcohol? YES or NO Number of drinks a day:_____

Do you use any illicit substance including street drugs (crack, cocaine, heroin, stimulants, marijuana, benzodiazepines) or prescription medications not prescribed to you? YES or NO
Have you ever been treated for a substance abuse problem? YES or NO

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Release of Medical Records

I authorize the below named health care provider to release the information or records specified upon request to Olive Branch Integrative Mental Wellness, LLC.

Provider Name: _____ Phone #: _____Fax #:_____

Please release the information to:
Olive Branch Integrative Mental Wellness, LLC
31 Gooden Ave Dover, DE 19904
P: (302) 480-9422 F: (833) 974-3996

Patient Name_____

☐ Entirety of Medical Record during the time I was under the providers care ***OR FROM THE FOLLOWING DATES***
Medical Record from: ____/____/_____ to ____/____/_____

Specific Information Authorized to be released:

☐ Entire Medical Record: Including patient histories, office notes, test results, all mental health records including substance abuse notes, referrals, billing records, insurance records, and records received from other healthcare providers.
OR OTHER :_____

This information will be used for the purpose of the following as needed:
- Investigating an allegation of abuse - Legal Representation - Providing advocacy services
- Other activities at the request of the individual - Verifying my eligibility for services offered

*I understand that I am not required to sign this authorization and that my health care or payment for care will not be affected by my refusal

*Federal privacy regulations will no longer apply to the information disclosed and that Olive Branch Integrative Mental Wellness, LLC may redisclose the information.

*I am entitled to receive a copy of this authorization

*A copy of the authorization may be utilized with the same effectiveness as an original

_____ _____
Signature of Patient or Representative Date

Olive Branch Integrative Mental Wellness, LLC
HIPPA Notice of Privacy Practices

In accordance with the law, Olive Branch Mental Wellness, LLC supports and upholds all matters pertaining to the privacy of your protected health care information. We will fully adhere to all legal requirements regarding your protected health care information but reserves the right to change our privacy practices at any time as permitted by the law. If our privacy practices change, we will post a notice in our reception area, and provide you with a copy of the document changes.

CLIENT CONSENT FOR DISCLOSURE AND USE OF PROTECTED HEALTH INFORMATION

I hereby consent to the utilization and disclosure of my protected health information by Olive Branch Integrative Mental Wellness, LLC. In addition, I give my consent to provide treatment and secure payment, and other health care operations as related to my care. I have read/reviewed the Privacy Practice Statement (as above), prior to signing this consent, I understand that Olive Branch Integrative Mental Wellness, LLC is required by law to report suspected or diagnosed child abuse and neglect; and conditions identified as "reportable conditions" by statue to the State Public Health Office.
Olive Branch Integrative Mental Wellness, LLC may mail to my home, or other designated location, may correspond with me via telephone, leave verbal messages on my voicemail, or speak with me in person, in reference to any items or issues that will assist in the provision of my care, payment, and or other health care operations such as, insurance item, follow-up communication, X-ray and / or laboratory results, or other, pertaining to my care. This includes the transfer of my protected health information (if required by postal mail, as long as the consents are addressed to me personally and are marked "personal and confidential" or are delivered by Olive Branch Integrative Mental Wellness, LLC. I further realize that I have the right to request that Olive Branch Integrative Mental Wellness, LLC, restrict the use / disclosure of my personal health information regarding treatment, payment, and / or other health care operations or activities. However, Olive Branch Integrative Mental Wellness, LLC is not required to agree to my requested restrictions. Olive Branch Integrative Mental Wellness, LLC does not agree to my requested restrictions; they are bound by the legal constraints regarding the privacy and protection of my health care information.

I have read and understand the Notice of Privacy Practices and Consent for Use and Disclosure of Protected Health Information. I authorize Olive Branch Integrative Mental Wellness, LLC to use or disclose my protected health information to carry out my treatment, to obtain payment from my insurance company, and for health care operations like quality reviews, checking the prescription drug monitoring program, accessing the Delaware Health Information Network, and checking my external prescription history.

Please be advised: It is Well Healthcare, LLC office staff will have access to patient charts for Olive Branch Integrative Mental Wellness, LLC.

Printed name: _____ Signature: _____

Date: _____

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Olive Branch Integrative Mental Wellness, LLC
HIPAA Consent

I, _____ authorize the persons listed below to give or receive any information via telephone, mail, or in-person which would be of benefit to my care or wellbeing. I am aware that Olive Branch Integrative Mental Wellness, LLC will not be responsible for the handling of any information released to the persons that I have listed below.

Name (First/Last)	Relation	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____

Parent/Guardian/Patient Name (Print) Parent/Guardian/Patient Name (Sign)

Date: _____

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Patient Financial Responsibility

1. Direct Pay Only

I understand that **Olive Branch Integrative Mental Wellness, LLC** is a **self-pay only practice as of September 1, 2025**. This means:

- The practice does **not participate with any insurance plans**.
- I am **responsible for payment in full at the time of service**.
- The practice may provide me with a **superbill** upon request, which I may submit to my insurance for possible out-of-network reimbursement. I may also opt to have Olive Branch Integrative Mental Wellness, LLC submit a superbill on my behalf however, **the practice does not guarantee any reimbursement** from my insurance provider.

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2. Fees

- **New Patient Evaluation (90 minutes):** $375.00
- **Follow-Up Session (30 minutes):** $150.00 **Follow-Up Session (60 minutes):** $295.00
- **Additional ADHD Evaluation (computerized testing):** $75.00

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3. Payment Policy

- Payments are due **at the time of service** by [credit/debit card, HSA, check, or cash].
- A valid credit/debit card may be kept on file to secure appointments.

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4. Cancellation & No-Show Policy

- Appointments must be canceled or rescheduled **at least 24 hours in advance**.
- Missed or late-canceled appointments will be charged **a $50.00 fee**.

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5. Acknowledgment

I have read, understood, and agree to the above self-pay policy. I understand that I am responsible for all charges incurred and that insurance reimbursement is not guaranteed.

Patient Signature: _____ **Date:** _____

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Office Policies and Procedures

Welcome to Olive Branch Integrative Mental Wellness, LLC. Please review the following so you are aware of the policies of my practice and contact me with any questions. Once you have signed this agreement, I will assume you have read and understood it. Thank you and I look forward to working with you.

Confidentiality: Our sessions are confidential and what we discuss may not be revealed to anyone without your permission except where disclosure is required by law. Disclosure may be required where there is a reasonable concern of: 1) abuse or neglect of a child, 2) danger of harm to yourself or others, 3) grave disability, or 4) in the case of a legal proceedings. I may find it helpful to consult other professionals about your case; however, neither your name nor any identifying information about you is revealed. In the case that another person (such as a family member or friend) is paying for your treatment, that person will not receive any confidential information about your care without your explicit written consent.

Initial Consultation: Our first visit will be a consultation for the purpose of evaluation. After evaluation, I will offer some first impressions of what our work might include, a treatment plan, and considerations regarding psychotherapy, medications, and holistic approaches. You may use this information—along with your own comfort in working with me—to make your decision as to whether you would like to pursue treatment. If you do not feel comfortable working with me, or if I do not feel able to help you for any reason, I will try to assist you with referral to others who may be able to meet your needs.

Follow Up Appointments: Regular follow up appointments are required in order to ensure good care. Follow up appointments are scheduled for either 30 minutes or 55 minutes depending on the complexity of the issue and whether we are setting aside time for psychotherapy. The appointment time is reserved for you, so it is important that you are on time. If you are late, your appointment will still conclude at the end of your scheduled appointment, or your appointment may have to be forfeited. If you miss or have to cancel an appointment, please reschedule within 30 days. If I do not hear from you within 90 days of a cancelled or missed appointment, I will assume you are receiving your care elsewhere and administratively discharge you from my practice. Please be aware that once discharged, I may not be able to accept you back into my practice should you follow up with me in the future.

Fees Structure

- **New Patient Evaluation (90 minutes):** $375.00
- **Follow-Up Session (30 minutes):** $150.00 **Follow-Up Session (60 minutes):** $295.00
- **Additional ADHD Evaluation (computerized testing):** $75.00.

Contact & Follow Up: I am available by phone, patient portal or email during business hours. I will return messages in a timely fashion, typically within 24-48 hours. In case of an emergency, please call 911 or go to your nearest emergency room. I am not available during evenings or the weekends however, if you are in crisis, please leave me a message and I will return your call. Leaving a message is not a substitute for call 911 or mobile crisis as these 2 resources can evaluate and treat you immediately on a 24/7 basis.

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Cancellations and Missed Appointments: Should you need to cancel, please do so at least 24 business hours in advance. Business days are considered weekdays and exclude holidays. Cancellations made with less than 24 business hour's notice, or missed appointments, are charged $50.00. For example: an appointment scheduled for 12pm on Monday must be cancelled by 12pm on Friday to avoid incurring a fee.

Communication: I am available to communicate with patients via their portal or email because of the convenience it allows. However, email is not a completely secure means of communication because messages can be addressed to the wrong person or accessed improperly while in storage or during transmission. I do not receive emails after hours, on the weekends, or on vacation. In the case that I am on vacation and unavailable, I will have a colleague providing coverage for me. Complex clinical questions should be discussed during appointments as opposed to over email. *Please do not text the office or private message the practice through social media platforms. *

Billing and Payment Policies: Payment is expected at the time the service is provided. Outstanding balances are expected to be paid prior to the next visit. Continued non-payment for services may lead to discharge.

Insurance Coverage: I am not in-network for any insurance panels, including Medicare, and am considered an "out of network provider" for PPO plans. While I do not contract with insurance companies, I do assist my patients by providing the paperwork necessary to submit into their insurance carriers for reimbursement (a "superbill"). I am "opted out" of Medicare and if you are covered by Medicare you will need to sign an additional consent acknowledging that Medicare will not reimburse you for my services. I am not able to negotiate or submit claims with insurance companies. Please be aware that your insurance provider may not reimburse you for any, or may only reimburse you for a part of, the charges for my services. Insurance companies generally do not reimburse for administrative services or missed appointments.

Medication Refills: Medication refills will be sent electronically to your pharmacy. I typically submit refills during scheduled appointments, but as long as you are coming for regularly scheduled appointments at the minimum of every three months, I can provide medication refills between appointments. Please request medications prior to running out. Please allow 3 business days for me to respond to refill requests and do not leave these requests to the last minute. If you have not been seen in over three months, you may need to schedule an appointment to obtain a refill.

Please be aware than when prescribing medications for my patients I will routinely check medication prescription history via available platforms, including DHIN and DPDMP, a centralized database that shows patients' medication prescriptions from different providers, in order to ensure safe care.

Controlled Substances: In some cases I may prescribe controlled substances (such as benzodiazepines or stimulants) as part of your care. It is important to take these medications as prescribed, and not to increase or change your dose without specifically discussing with me. In the case that you change your medication dose on your own and run out early, I will not provide an early refill and you may experience withdrawal symptoms.

I agree to take any controlled substance prescriptions exactly as prescribed and not to increase my dose without specifically addressing it with Morgan Webb, PMHNP. I agree not to obtain duplicate prescriptions for controlled substances prescribed by Morgan Webb, PMHNP from other physicians while undergoing treatment with her.

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Prior Authorizations: Most medications I prescribe are covered by insurance, but insurance companies sometimes require prior authorization for certain expensive or brand name medications. I cannot guarantee a medication I prescribe will be covered by your insurance, but I will do what I can to make it as likely as possible by submitting medical justification to your insurance company.

Limits of Service: I do not provide disability evaluations, worker's compensation evaluations, forensic evaluations, or provide legal services or testimony. Should you require legal testimony at some point during our treatment together, you will need to retain an independent forensic psychiatrist.

Treatment Termination: Ideally, termination of services would occur when the goal of the client is met, and treatment/continued follow-up is no longer warranted. As our client, you have the right to terminate services at any time. If at any point in treatment we feel that we can no longer continue your care, written notice will be provided as well as a 30-day supply of your current psychotropic medication (if appropriate) will be sent to your pharmacy, and a list of providers in the area who may be available to continue your care will be provided.

Other situations that may require termination of treatment include non-compliance with any of the visit rules noted in this packet, threatening/violent behavior towards staff/provider, misuse of medication, constantly using inappropriate forms of communication with the office, arriving under the influence of illicit substances, and or disclosing illegal intentions or actions.

I have reviewed the above policies and agree to abide by the terms of this agreement.

Printed Client Name: _____

Client Signature: _____

Date: _____

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Consent for Treatment

1. Purpose of Treatment

I voluntarily consent to psychiatric evaluation, diagnosis, and treatment provided by **Olive Branch Integrative Mental Wellness, LLC**. Treatment may include, but is not limited to:

- Psychiatric evaluation and diagnostic assessment
- Psychotherapy
- Medication management
- Nutraceutical or supplement recommendations (if applicable)
- Lifestyle coaching
- Referrals for additional services, if appropriate

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2. Potential Risks and Benefits

- I understand that psychiatric treatment may have benefits, including improved mental health and quality of life.
- I understand that no specific results can be guaranteed.
- I understand that potential risks may include side effects of medications, emotional discomfort, or limited improvement.

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3. Medications (if applicable)

- I understand that if medications are recommended, the purpose, benefits, risks, and possible side effects and adverse effects will be explained to me.
- I understand I may accept or refuse medications and may withdraw consent at any time.

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4. Telehealth Services (if applicable)

- I understand that treatment may be provided through secure telehealth platforms.
- I understand the risks and limitations of telehealth, including potential technical issues and limits on confidentiality.

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5. Confidentiality

- I understand that my treatment records are confidential and protected by law.
- Information may only be released with my written consent, except as required or permitted by law (e.g., risk of harm to self/others, suspected abuse, court order).

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6. Emergencies

- I understand that Olive Branch Integrative Mental Wellness, LLC is **not a 24-hour crisis service**.
- In the event of an emergency, I will call **911** or go to the nearest emergency department.

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7. Financial Responsibility

- I understand this is a **Direct Pay Only** practice.
- I agree to pay fees at the time of service, as outlined in the Self-Pay Agreement.

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8. Patient Rights

I understand that I have the right to:

- Ask questions about my treatment.
- Be informed of alternatives.
- Refuse or discontinue treatment at any time (with the understanding that abrupt discontinuation may have risks).

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9. Consent

I have read and understood the information in this form. I have had the opportunity to ask questions, and all questions were answered to my satisfaction. I voluntarily give my consent for treatment.

Printed Name of Patient/Guardian: _____

Patient/Guardian Signature: _____

Date: _____