Morgan Webb, MSN, PMHNP-BC
31 Gooden Ave Dover, DE 19904
P: 302-242-5463 F: 885-583-3724
Frontdesk@obintegrative.com
Healow Portal Code: CGGBDD

Welcome to Olive Branch Integrative!

Welcome, and thank you for considering Olive Branch Integrative Mental Wellness, LLC for your mental health care. We are honored to support you on your journey toward well-being and balance.

At Olive Branch Integrative, we provide comprehensive, compassionate care rooted in an integrative mental health approach—addressing the whole person, not just symptoms. Our goal is to create a collaborative space where you feel seen, supported, and empowered.

We currently operate as a practice that accepts most major insurances, however, beginning **September 1st 2025 we will no longer be accepting any insurance, we will operate as a fee-for-service (self-pay) practice only** , which will allow us to focus more directly on your care, free from insurance constraints. Please note our current self-pay rates and the changes that will be implemented effective through September 1, 2025:

- New Patient Evaluation Starting September 1st $375.00

- Standard Provider Starting September 1st: $150.00 for 30 minutes or $295.00 for 55 minutes (55 minute follow-ups are for those incorporating therapy into their sessions).

We'll always be transparent about costs and happy to answer any questions you may have. Payment is due at the time of service, and we can provide a superbill upon request should you wish to seek reimbursement from your insurance provider.

We're truly looking forward to working with you!

Olive Branch
Integrative Mental
Wellness

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? _____

Olive Branch
Integrative Mental
Wellness

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: _____

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):_____

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

Olive Branch
Integrative Mental
Wellness

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

Morgan Webb, MSN, APRN, PMHNP-BC
31 Gooden Ave Dover, DE 19904
Olivebranchintegrative@proton.me
P: 302-242-5463
F: 885-583-3724

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) 302-242-5462 (F) 855-583-3724

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: _____

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: _____

Olive Branch Integrative Mental Wellness, LLC

Patient Financial Responsibility

I (We) jointly and severally, agree to pay all the charges for professional services rendered to the patient.

I (We) understand that these changes are in addition to charges by a hospital or other medical professional rendering services to the patient.

I (We) Promise to pay the charges in full at the time a bill is presented, unless other terms have been agreed to in writing. In the event prompt payment is not made, the undersigned understands that the account may be referred for collection. In such an event any unpaid balance shall accrue interest at the rate of 2% of the amount due. We also use third-party vendors such as LabCorp, Quest, and Bayhealth for labs, imaging and studies. If you are self-pay and or your insurance does not cover these vendors you may receive a bill for their products and services in which you agree and would be financially responsible to pay these vendors directly.

If the patient has provided insurance information, Olive Branch Integrative Mental Wellness, LLC may, but it is not required to assist the patient in the filing of a claim.

I request and authorize that payment of authorized Insurance Company out of network benefits (if applicable) may be made on my behalf to Olive Branch Integrative Mental Wellness, LLC for any services furnished to or by this company as a superbill post apportionment.

I authorize any holder of medical information about me to be released to any insurance company (s) any information needed to determine benefits payable to related services.

I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. In Medicare / other insurance company assigned cases, Olive Branch Integrative Mental Wellness, LLC agrees to accept the charge determination of the Medicare/other insurance company as the full charge, The patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurance and the deductible are based upon the charge determination of the Medicare / other insurance company.

Printed Name: _____ Date:_____

Signature: _____

Olive Branch Integrative Mental Wellness, LLC
Rules and Regulations / Consent to Treat

Visit Rules

Every client must bring their identification card and insurance card to every visit. Please notify the office immediately if your insurance changes.

By Federal Law and Managed Care Contract Law, this office is required to collect copayment and deductible for each encounter. Copayments are due at the date of service.

We respectfully request a 24-hour advance notice if you need to reschedule or cancel your appointment. Doing so after this period of time will result in a no-show and potential charge of $50.00.

Olive Branch Integrative, LLC has a zero tolerance policy for disrespect to staff including using inappropriate language, gestures, or volume towards a staff member. Inappropriate behavior may warrant an immediate discharge from our office.

INITIAL_____

Prescription Medications

Please allow 24 to 48 hours for all prescription refills to be completed by the office once the request is received. Please be sure to **call in to the office or request your refill through your patient portal (these are the only acceptable methods of request)** at least **3 business days** prior to your last dose, this will help to prevent you from being out of medication(s). Make sure to call your pharmacy before picking up the medication to make sure the prescription is ready. Medication refill requests on the weekends are never guaranteed.

*Controlled medications will be filled no sooner than **2 days** prior to their last retrieval from the pharmacy. Repeated requests to refill controlled substances early may warrant a discharge from the practice.* Please be advised per best practice guidelines clients on any form of controlled substance will be required to provide a urine drug screen at random.

INITIAL_____

Communication With Provider

Please be advised that the only acceptable forms of communication with the provider/staff are a phone call to the office or through a message in your patient portal (Healow Application). If we are in session, we may not answer the phone; however, the phone line is monitored constantly. Clients must leave a voicemail for a returned call if a member of the staff does not answer.

**** Please do not text the office or private message the practice through social media platforms. In the event of a crisis, the only acceptable form of communication is a call to the office.***

INITIAL_____

Olive Branch Integrative Mental Wellness, LLC
Rules and Regulations / Consent to Treat Continued

Appointment Reminders

Please initial on the line below if you allow the office to text and or leave a message on your voicemail in regards to any appointment reminders. If you opt out of the service you will need to remember your appointments autonomously.

INITIAL_____

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.

CLIENT SIGNATURE: _____DATE: _____

CONSENT TO TREAT

I HEREBY AUTHORIZE OLIVE BRANCH INTEGRATIVE MENTAL WELLNESS, LLC TO EVALUATE AND TREAT ME FOR MY PRESENTING CONDITION. I UNDERSTAND THAT THE PROVIDER EVALUATING ME MAY IN HER PROFESSIONAL OPINION, DETERMINE THAT I NEED TO BE TRANSFERRED TO A HIGHER LEVEL OF CARE SUCH AS THE EMERGENCY DEPARTMENT OR FOR INPATIENT EVALUATION SHE MAY BE LEGALLY OBLIGATED TO DO SO. I AGREE TO PAY FOR ANY AND ALL MEDICAL SERVICES RENDERED AT OLIVE BRANCH INTEGRATIVE MENTAL WELLNESS, LLC.

CLIENT SIGNATURE: _____DATE: _____

Olive Branch
Integrative Mental
Wellness

Patient Financial Responsibility and Self-Pay Consent Form

Olive Branch Integrative Self-Pay rates as of **September 1, 2025:**

$375.00 New Patient Evaluation

$150- 30-minute Follow-Up

$295- 55-minute Follow-up

I attest that:

This self-pay agreement is intended to provide patients and parents/legal guardians with an understanding of their financial responsibilities should they elect to self-pay for Olive Branch Integrative Mental Wellness, LLC services.

By signing this agreement, I, (patient or parent/legal guardian), _____ understand and agree that:

1. I represent that (check appropriate box below)
   - ☐ I have health insurance coverage; however, Olive Branch Integrative, LLC does not currently accept my health insurance plan and won't be accepting any insurance as of September 1st 2025.
   - ☐ I do not currently have health insurance coverage.

Signature: _____Date: _____

Appointment Cancellation/No Show Policy

Thank you for trusting your mental healthcare to Olive Branch Integrative Mental Wellness, LLC. When you schedule an appointment with Olive Branch Integrative Mental Wellness, LLC we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. Please see our appointment cancellation/no show policy below:

- Effective November 1, 2024, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24-hour notice will be considered a no show and charged a $50.00 fee.

- If a third no show or cancellation/reschedule with no 24-hour notice should occur the patient may be dismissed from Olive Branch Integrative Mental Wellness, LLC

- Any new patient who fails to show for their initial visit will not be rescheduled after their second no show.

- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

- As a courtesy, we make reminder calls for appointments. If you do not receive a reminder cal or message, that above policy will remain in effect.

- There is a 10-minute window before you are considered to be a no show.

We understand that there may be times when an unforeseen emergency occurs, and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our office, who may be able to waive the no show fee. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms:

Printed Name: _____ Date: _____

Signature of patient: _____