Midlothian
Behavioral Health Associates
TMS Center of Richmond

Thank you for choosing Midlothian Behavioral Health Associates, LLC.
In order to serve you better we require the following information.
All information is considered confidential. **Please Print.**

Name: _____ **DOB:** _____ **Gender:** ___Male ___Female ___X

Preferred Name: _____ **SSN:** _____ **Marital Status:** __Single __Married __Divorced __Widowed

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____ **Ext.**_____

Email: _____ **Appointment Reminder:** ☐ **Call** ☐ **Text** ☐ **Email**

INSURANCE INFORMATION (Primary)

Insurance Company Name: _____

ID: _____Group#:_____ Effective /Issue Date: _____

Guarantor Name: _____ DOB: _____ Phone: _____ Relationship to Insured: _____

INSURANCE INFORMATION (Secondary)

Insurance Company Name: _____

ID: _____Group#:_____ Effective /Issue Date: _____

Guarantor Name: _____ DOB: _____ Phone: _____ Relationship to Insured: _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

EMERGENCY CONTACT

Emergency Contact: _____ **Phone:** (_____) _____ **Relationship:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

I give MBHA permission to discuss the following with the individual above: (check all that apply)

☐ **Appointments** ☐ **Billing** ☐ **Treatment/Medication**

Patient Signature: _____ **Date**: _____

AUTHORIZATION FOR CLAIMS, PAYMENT AND REVIEWS

Please understand that payment of your bill is considered a part of your treatment.
The following is a notice of how our claims, payment and policies are upheld. Please read and sign this page prior to treatment.

Full payment for professional services is due at the time of services.

As a courtesy, we will try to contact your carrier to confirm coverage and estimate their payment for services rendered**. It is ultimately the responsibility of the patient to know what type of treatments and services are covered under their individual insurance plan. We require you to make your payment at time of services**

NOTICE TO TRICARE BENEFICIARIES

If you are a TRICARE beneficiary, the prior paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a TRICARE beneficiary. If the services to be rendered to you are excluded from your TRICARE benefits, your payment option for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as a TRICARE benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

Please be aware that very few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the cost. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorization for medical treatment. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file your claim with your insurance carrier and reimburse you if they issue a payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please Initial Terms below:

I, authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my condition, which may include records related to treatment for substance abuse to my insurance carrier(s), managed care plan or other party, past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law**. (Initial)_____**

In my capacity as a patient, legal representative or representative payee for the patient, I agree to pay all the charges for which I may be legally responsible including but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs. **(Initial)_____**

By signing below I certify that I have read and understand the Authorization for Claims, Payments, and Reviews, have had the opportunity to ask questions and have them answered and accept the above condition and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

_____**Date**_____

Patient Name (please print)

_____ _____

Signature (Patient or Responsible Party) Relationship to patient (Guardian/Parent)

Office Policies

- **Co-Payments/Balance:** Co-payments and deductibles must be paid upon the patient's arrival. Any patient with a balance **over 30 days <u>will have to pay in full or reschedule</u> their appointment**. We accept cash, Discover, Visa, and MasterCard.

- **Non-covered Services:** Must be paid for at the time of service.

- **Tardiness:** Please call if you running late. Patients arriving more than 15 minutes late may be asked to reschedule. We will try to deliver the same respect for your time if we are running late the session will be completed in its entirety.

- **Cancellations:** We require that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time. Patients that do not contact the office within the 24 business hour period to cancel or reschedule their appointment will be charged a $50-$125 fee (depending on provider and appt type) for the missed appointment.

- **Missed Appointments:** We may be unable to schedule future appointments for patients having ***missed appointments and/or cancellations without appropriate notice,*** particularly if the provider feels that these missed appointments are adversely affecting the treatment plan. Failure to comply may result in discharge from the practice. ***Please be advised that failure to receive an e-mail or phone call reminder does not absolve you from keeping track of your own appointment.***

- **Declined cards for telehealth appointments:** If your card on file is declined for your copay at the time of your telehealth visit, you will not receive your link to your appointment. This may result in the "missed appointment fee" and you must pay when scheduling your appointment going forward.

- **Returned Checks/Declined cards for balances**: Returned checks and declined cards will be processed with a service charge of $40. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

- **Paperwork Charge:** $50 charge for paperwork, reports, etc. Requests exceeding (2) pages may incur additional fees. These paper work requests will take up to the allowed (10) business days from the date we receive written request. A charge of $5.00 will be applied for medical records requested by the patient, record requests can take up to 30 days. Patients requesting records must be present to pick-up requested records and sign a release in receipt of their records. We do not email records, we are happy to fax or mail records as per your request.

- **Medication Refills: APPOINTMENTS ARE REQUIRED FOR REFILLS. All prescriptions will be filled at your appointment with sufficient refills to last until the next scheduled appointment. It is advised that you schedule your next follow up appointment at the end of each appointment.** In the event that you run out of your medication and have not scheduled your follow up appointment in time, there may *be a* ***$15.00 prescription processing fee.***

- **Primary Care Referrals:** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.

- **Subpoena for Witness:** If any of the providers are subpoenaed for court, the fee is $250/hr. for a minimum of 4 hours. This fee includes preparation time, travel, waiting, testifying, etc. Additional fees may be assessed if travel out of the immediate area is required. Payment in full is required 7 business days in advance of the scheduled hearing. This fee continues to apply even if the provider does not testify. Additionally, fees will remain in effect in the event that court is canceled, continued, or rescheduled less than 3 business days prior to the court appearance for any reason. (e.g. weather, the judge cancelling the day, settlement of the case outside of court, etc.).

- **PMP (Prescription Monitoring Program):** The provider will be checking the PMP prior to prescribing any controlled substances.

- Any behavior, words, or actions towards staff or providers that are disrespectful, hostile or harassing will not be tolerated.

- **Failure to comply with any of the office policies may result in discharge from the practice.**

X._____ _____

Signature of Patient/Responsible Party Date

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Midlothian Behavioral Health Associates, LLC. As your healthcare provider, the medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from Midlothian Behavioral Health Associates (MBHA, LLC), you agree:

1. You acknowledge and agree to the established policies and procedures of Medical Associates, including but not limited to this PATIENT FINANCIAL RESPONSBILITY STATEMENT, in effect from time to-time ("Policies"). You may request a copy of the current Policies from the Business Office Staff. These Policies may be changed from time to time by MBHA LLC, without notice. If there is any conflict between another policy or procedure of MBHA, LLC and this PATIENT FINANCIAL RESPONSIBILITY STATEMENT, this Statement shall control.
2. **You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services**. You are responsible for deductibles, co-payments, co-insurance amounts or any other patient responsibility indicated by your insurance carrier or our Policies, which are not otherwise covered by supplemental insurance.
3. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) **your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at MBHA, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral;** (iii) **your health plan determines that the services you received at MBHA are not medically necessary and/or not covered by your insurance plan**; (iv) your health plan coverage has lapsed or expired at the time you receive services at Medical Associates; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
4. By signing below, you authorize MBHA to verify your insurance benefits and submit your claim to your insurance carrier or other plan provider. You agree to facilitate payment of claims by contacting your insurance carrier or other plan provider when necessary. Without waiving any obligation to pay, you assign to MBHA, for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare or Medicaid), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. I**t is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. MBHA does not accept responsibility for incorrect information given by you or your insurance carrier or other plan provider regarding your insurance benefits or benefit plans.**
5. I**f your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges within the terms set forth herein. Once your insurance carrier processes your claim, we will bill you for any remaining patient responsibility deemed by your insurance carrier.** If any payment is made directly to you for services billed by us, you agree to promptly submit same to MBHA until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize MBHA to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a Financial Responsibility Party, and any remaining balance will be returned to the payor.
6. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). You may generally expect this billing statement within twenty (20) days after your insurance company has responded to a submitted claim. You must notify us of any errors or objections to the billing statement within thirty (30) days or they will be deemed accurate, and the fees and expenses shall be deemed reasonable and necessary for the services incurred. If there is a problem with your account, it is your responsibility to contact the Patient Accounts Staff to address the problem or to discuss a workable solution.
7. Whether or not you have insurance or are self-pay, payment of any account balance is due at our Patients Account Offices in Midlothian, VA within thirty (30) days of the claim.
8. It is your responsibility to update your mailing address immediately should it change. Failure to update the address and receive a billing statement does not excuse you for late payment.
9. We accept payment by check, cash, money order, debit cards or credit cards. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, you understand that MBHA has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. You are responsible for all costs of collection.

Financial Responsibility Acknowledgement

By signing below, each of the undersigned acknowledges that: (i) I have been provided a copy of the Midlothian Behavioral Health Associates, LLC (MBHA, LLC) PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to MBHA, LLC for the below Patient's care and treatment, including co-payments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered; (vi) if I failed to make any of the payment for which I am responsible in a timely manner, I will be responsible for all costs of collecting the money owed, including court costs, collection agency fees, and attorneys' fees (to the extent allowed by law); and (vii) failure to pay when due may subject me to late payment charges and can adversely affect my credit report. I further agree that a photocopy of this Patient Responsibility Financial Statement shall be as valid as the original.

ONCE I HAVE SIGNED THIS AGREEMENT, WHETHER BY ORIGINAL, FACSIMILE OR ELECTRONIC (".PDF") SIGNATURE, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

_____ _____ _____

Patient Full Name (please print) Date of Birth Date

_____ _____

Patient/Responsibility Party/Guardian Signature Office Witness

Waiver of Patient Authorizations

I **do not** wish to have information released and prefer to pay at the time of service and/or to be fully responsible for payment of charges and to submit claims to insurance at my discretion.

_____ _____

Signature of Patient/Responsible Party/Guardian Date

PAYMENT AGREEMENT & AUTHORIZATION FORM

By signing this document I, the undersigned, indicate that I have fully read and understand the Financial Policy of Midlothian Behavioral Health Associates, LLC. I agree to cooperate with the billing department of this practice to ensure payment for services I receive. I further understand that I will be responsible for the cost(s) associated with the collection of my account if I default on this agreement.
The terms of this policy may be amended at any time without prior notification.
MBHA requires a credit card on file for all patients. Copay's and self-pay rates will be processed the morning of your appointment. I understand that it is my responsibility to update my card on file. If my card declines, will be required to pay my visit amount prior to scheduling going forward. Balances over 90 days will be processed automatically unless a payment plan is made with the billing office.

Cards may be processed for the following:

- Copay's/Self-pay rates
- No Show/Late cancel fees $50-$125
- Paperwork $50
- Refill's outside of your appointment $15 *terms apply
- Balances over 90 days old
- After hours provider call $70
- Records Request

I have read and understand all of the above.

Full Name: _____ DOB: _____

Signature: _____ Date: _____

Informed Consent for Treatment and Release of Information

I voluntarily consent to care and treatment by Midlothian Behavioral Health Associates, LLC. I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history. I understand that our work will be kept confidential with the exception of legal limitations on confidentiality. I am aware that, although my provider is a clinically independent practitioner, consultations with associates are at times clinically advisable and my signature below gives them permission to do that. The associates also provide emergency coverage for each other when one is out of town, and I understand that an associate providing coverage for my provider may need access to relevant information to provide the best interim care possible. I have the right to revoke this consent in writing and terminate services at any time.

PRIMARY CARE PHYSICIANS/REFERRING PHYSICIAN/THERAPIST

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. **Please make a selection below**.

☐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Therapist as follows:

Name of PCP/Referring Physician: _____ Phone:_____

Located at: _____

Name of Therapist: _____ Phone:_____

Located at: _____

☐ I **do not** wish to have information regarding my treatment with this practice released to my PCP/Referring Physician/Therapist.

REALITIVES, FRIENDS AND OTHER CAREGIVERS

I agree that MBHA may disclose health information to a personal representative of my choosing. MBHA will disclose only information that is indicated in the boxes I checked below each representative.

Name: _____ Relationship: _____ Phone:_____

☐ **Appointments** ☐**Billing** ☐ **Treatment/Medication**

Name: _____ Relationship: _____ Phone:_____

☐ **Appointments** ☐**Billing** ☐ **Treatment/Medication**

COMMUNICATION

I hereby understand that by checking the options below, I am allowing MBHA to send information about my appointments or bill via voice, email, or text message. Please check all that apply. ***Please be advised that failure to receive a reminder does not absolve you from keeping track of your own appointment.***

__Home Phone __Cell Phone __Work Phone __Email

X _____ **_____**

Patient Printed Name **Patient DOB**

X_____ **Date: _____**

Patient Signature (or parent/guardian)

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that: I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Patient or Guardian: _____ Date: _____

Printed Name of Individual or Guardian: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgement.
_____ Emergency situation prevented us from obtaining acknowledgement.
_____ Other (please specify)
_____

Office Staff Signature_____**Date**:_____

Midlothian Behavioral Health Associates, LLC

14410 Sommerville Ct. Suite 101
Midlothian, VA 23113

804-897-9355 OFFICE
804-897-9359 FAX

Patient Questionnaire - PHQ-9

Patient Name: _____ DOB: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all 0	Several days 1	More than half the days 2	Nearly every day 3
1. Little interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleep too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself - or that you're a failure or have let yourself or family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	☐	☐	☐
	0			

A.) How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

B.) In the past two years have you felt depressed or sad most days, even if you felt okay sometimes?

☐ Yes ☐ No

Severity Score: _____

*Name*_____ *DOB:* _____ *Today's date:* _____

Symptoms/Health History

Current Symptoms *(Please check all that apply)*

- ○ Anxiety or nervousness
- ○ Shortness of breath
- ○ Feeling of heart pounding in chest
- ○ Sweating
- ○ Chest pain
- ○ Nausea
- ○ Stomach discomfort
- ○ Recurrent obsessive thoughts or actions
- ○ Racing thoughts
- ○ Easily distracted
- ○ Hearing voices or seeing things
- ○ Decreased appetite
- ○ Increased appetite
- ○ Significant recent weight loss
- ○ Significant recent weight gain
- ○ Alcohol use
- ○ Thoughts of death or suicide
- ○ Depressed or sad feelings most of the day
- ○ Loss of interest or pleasure in daily activities
- ○ Fatigue or low energy
- ○ Guilty feelings
- ○ Poor concentration
- ○ Anger or irritability
- ○ Inflated self-esteem
- ○ Increased energy (more than normal)
- ○ Impulsivity
- ○ Feeling paranoid (like people are out to get you)
- ○ Preoccupation about current weight
- ○ Excessive exercising/purging to reduce weight
- ○ Decreased sleep
- ○ Increased sleep
- ○ History of illicit drug use

Medical History

○ Diabetes	○ High blood pressure	○ Heart disease	○ Increased Cholesterol	○ Asthma/COPD
○ Gastrointestinal	○ Thyroid problems	○ Stroke or TIA	○ Head Injury	○ Seizure disorder
○ Chronic pain	○ Migraines	○ Arthritis	○ Cancer	○ Glaucoma

○ Other significant medical issues _____

Allergies: _____

List of Current Medications

14410 Sommerville Ct
Suite 101
Midlothian, VA 23113
(P) 804 897-9355 (F) 804 897-9359
info@midlothianwellness.com
www. midlothianwellness.com

Consent to Participate in TeleHealth Appointments

I understand that my health care provider and I will communicate via secure interactive video conferencing; through https://doxy.me. My provider will send a link to my phone or email as an invitation to participate in the telehealth visit.

I understand that I should not be driving or engaging in any other activity that may be distracting during my Telehealth visit.

By signing this consent, I authorize my healthcare provider to release any relevant medical information pertaining to my medical condition and behavioral health care, to Midlothian Behavioral Health Associates, LLC, its providers and healthcare professionals. I authorize Midlothian Behavioral Health Associates, LLC and its healthcare professionals to release any and all information to my insurance company and any other party which may be responsible for paying my medical bill.

By signing this consent, I understand that Dr. Saleem will be checking the Prescription Monitoring Program (PMP) before prescribing any controlled substances.

By signing this consent, I understand that my card on file will be processed for payment of my visit. I understand that it is my responsibility to update my card on file. If my card declines, the appointment will not be completed and I will be required to pay my visit amount prior to scheduling going forward.

I have read this document carefully, and hereby consent to participate in the Telehealth visit under the terms that have been described above.

Please complete the requested information below and check **ONLY 1** preference of where you would like the link for your appointment to be sent.

☐ **Email:** _____ ☐ **Cell Phone:** _____

_____ _____
Patient First and Last Name Date of Birth

_____ _____
Patient Signature Date

****Please have your medication bottles with you prior to starting your telemedicine appointment****
We suggest you be somewhere quiet and away from distractions.