All information is considered confidential. **Please Print Clearly.**

Full 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**

Failure to receive reminders for appointments does not absolve you from keeping track of your appointment

INSURANCE INFORMATION (Primary)

Insurance Name: _____

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

Policy Holder Name: _____ DOB: _____ Phone: _____ Relationship to Insured: _____

INSURANCE INFORMATION (Secondary)

Insurance Name: _____

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

Policy Holder 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**

X._____ _____

Signature of Patient/Responsible Party Date

Authorization for Payment, Claims, and Reviews

It is your responsibility to provide accurate insurance information and obtain any referrals or authorizations required by your insurance plan prior to the start of your appointment. Claims are sent automatically immediately after your appointment concludes. If your insurance denies any of your services, if you are seen with inactive insurance, or seen without the proper referral/authorization, **you will be responsible for full payment of services rendered.**

We will assist you as best we can to determine your copay, deductible, and/or coinsurance amounts. Per our agreement with your insurance carrier, **you are required to pay any applicable copayments/coinsurances at the time of service.** Appointments will not be conducted if unpaid**.** Additionally, **if you have a high-deductible insurance plan and have not met your deductible, we will collect a down payment of at least $80 at each appointment.**

Please know that some insurance plans do not cover telehealth appointments. It is the patient's responsibility to confirm this with their insurance.

Balances must be paid in full before appointments may be conducted.

Refills and records may be held until balances are paid or a payment arrangement is in place.

Self-Pay / uninsured patients are required to pay for service in full at the time of service.
If you choose to be self-pay and forgo using your insurance, you agree to not submit any claims for MBHA's services to your insurance plan for reimbursement. Any payments you make to MBHA will not be credited toward satisfying any deductible or cost-sharing obligations you may have under your health insurance plan.
If you are choosing to be self-pay, please sign here: _____

Non-Covered

- Missed appointment/Cancellations without 24 business hour notice: $50 - $125
- Paperwork (FMLA, Disability, Accommodations, Letters): $25 - $50
- Returned checks & declined credit cards: $40
- Refills outside of appointments (*terms apply): $15
- After hours provider call: $70
- Records: Based on the number of pages and age of records. Base rate is $10.
- **Subpoena for Witness** $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 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.).

We accept payment by card, check, cash, or money order. Outstanding patient balances over 30 days will accrue a monthly $10 interest charge. Balances unpaid after 90 days from the date of service will have additional fees and be moved to collections. Should collection proceedings or other legal action become necessary to collect an overdue or delinquent account, 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. The patient will be responsible for all attorney and court fees.
By signing below, I certify that I have read and accept the terms above. I further certify that I am the patient, guardian, or duly authorized representative and am legally responsible.

X._____ _____
Signature of Patient/Responsible Party Date

Credit Card Agreement

MBHA requires every patient to have a card on file. This has become customary for all mental health practices in our area. Collecting for services is essential to allowing us to continue to provide care to you.

All card information is protected under HIPAA. We are under strict rules and guidelines in terms of patient privacy. We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for transactions. Once entered, we are only able to see the last four digits of the card number and expiration date. There is no way to export the card information out of our system. It can only be used for processing payments within our practice management system.

To reduce paper waste, only bills $100 and above are mailed monthly.
Charges may include:

- Copay/Co-ins/deductible/Self-pay rates
- No Show/Late cancel fees $50-$125
- Testing
- Paperwork $50
- Patient Letters $25
- Refills outside of your appointment $15 *terms apply
- After hours provider call $70
- Returned checks/declined cards $40
- Court fees
- Records Request base rate $10 (final amount depends on number of pages)
- Any balance under $100 put into “patient responsibility” due to a plan’s copay, deductible, co-insurance, or denial of service. Payment will be processed after the claim is finalized and when MBHA receives the copy of the explanation of benefits (EOB) from insurance (typical turn-around time is 14 – 30 days).
- Any balance past 90 days.
- Subpoena for witness $250/hr 4hr minimum
- Fees acquired from delinquent accounts.

I understand that it is my responsibility to update my card on file. If my card declines, I may be charged an additional fee and/or be required to pay my visit amount in full at time of scheduling going forward. Appointments will not be conducted if payment is not received. By signing this document, I the undersigned indicate that I have fully read and understand this financial policy of Midlothian Behavioral Health Associates, LLC. I agree to cooperate with the billing department to ensure payment for services I receive. I agree to not dispute payments with my card company, so long as the transaction corresponds to the terms indicated in this document and are for services I received. If I disagree with how my insurance processed a claim, I will contact my insurance directly. Payment plans may be available for large balances.

I have read, understand, and agree to the above.

X._____ _____
Signature of Patient/Responsible Party Date

Office Policies

- **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. **A 72 hour notice is needed for any testing appointment cancellations or reschedules.** Patients that do not contact the office accordingly will be charged a $50-$125 fee (depending on provider and appointment type) for the missed appointment.

- **Missed Appointments:** We may be unable to schedule future appointments for patients having ***2 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, text, or phone call reminder does not absolve you from keeping track of your own appointment.***

- **Tardiness:** Please call if you are running late. Patients arriving more than 10 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.

- **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 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.***

- A card is required to be on file for every patient.

- **Declined cards for telehealth appointments:** If your card on file is declined 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.

- **Forms/letters:** Forms and letters may take up to 10 business days from the date we receive written request and payment. Records requests may take up to 30 days. Patients requesting records must sign a proper release of information including all information and where it is to be released to.

- Patients are required to do a patient information update sheet yearly and provide copies of medical cards.

- **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.

- Patients being prescribed controlled substances will be required to sign an agreement.

- Patients are required to inform our practice in writing (email or letter) if they are leaving our care or are being seen at another practice.

- **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

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 the office, 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 from this office at any time.

HIPAA / Notice of Privacy Practices
I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information maintained here at Midlothian Behavioral health Associates. I 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 from time to time and that I may contact this facility at any time to request a current copy.

COMMUNICATION
I understand and consent to MBHA sending information about my appointments or bill via voice, email, or text message.

TELEHEALTH
I understand and consent that for telehealth appointments, my health care provider and I will communicate via secure interactive **video**; using https://doxy.me. I understand that it is my responsibility to confirm that telehealth appointments are covered by my insurance. I understand that I should not be driving or engaging in any other activity that may be distracting during my Telehealth visit. *Visits REQUIRE video access. Audio only visits are prohibited and will not be conducted*

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) 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:

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 (if different or in addition to emergency contact)
MBHA may 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

X._____ _____
Signature of Patient/Responsible Party Date

Patient Health 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: _____