Late Arrival Policy

Our providers, medical assistants and staff aim to make your visit a pleasurable one. In our efforts to make your visit more comfortable and to minimize your wait time, our office has implemented a late arrival policy. If a patient is more than 5 minutes late for a follow up appointment and 10 minutes for a new patient appointment, the appointment will need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients.

New patients are encouraged to print off new patient paperwork from the website and fill it out prior to coming in. Otherwise, new patients need to arrive at the office at least 1 hour prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we will need to reschedule so we can accommodate other patients who arrive on time.

The doctors and staff at Empower Wellness truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent medical care as well as excellent customer service.

Patient/Guardian Signature: _____

Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the *newspaper or watching television*	0	1	2	3
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 around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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
☐	☐	☐	☐

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family in trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	○	○

3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights?
Please check 1 response only.

○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem

4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry* 2000;157:1873-1875.

NICHQ Vanderbilt Assessment Follow-up—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: **Each rating should be considered in the context of what is appropriate for the age of your child. Please think about your child's behaviors since the last assessment scale was filled out when rating his/her behaviors.**

Is this evaluation based on a time when the child ☐ **was on medication** ☐ **was not on medication** ☐ **not sure?**

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
19. Overall school performance	1	2	3	4	5
20. Reading	1	2	3	4	5
21. Writing	1	2	3	4	5
22. Mathematics	1	2	3	4	5
23. Relationship with parents	1	2	3	4	5
24. Relationship with siblings	1	2	3	4	5
25. Relationship with peers	1	2	3	4	5
26. Participation in organized activities (eg, teams)	1	2	3	4	5

Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 0303

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Initiative for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

HE0352

D5 NICHQ Vanderbilt Assessment Follow-up—PARENT Informant, continued

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Side Effects: Has your child experienced any of the following side effects or problems in the past week?	**Are these side effects currently a problem?**			
	None	**Mild**	**Moderate**	**Severe**
Headache				
Stomachache				
Change of appetite—explain below				
Trouble sleeping				
Irritability in the late morning, late afternoon, or evening—explain below				
Socially withdrawn—decreased interaction with others				
Extreme sadness or unusual crying				
Dull, tired, listless behavior				
Tremors/feeling shaky				
Repetitive movements, tics, jerking, twitching, eye blinking—explain below				
Picking at skin or fingers, nail biting, lip or cheek chewing—explain below				
Sees or hears things that aren't there				

Explain/Comments:

For Office Use Only

Total Symptom Score for questions 1–18: _____

Average Performance Score for questions 19–26: _____

Adapted from the Pittsburgh side effects scale, developed by William E. Pelham, Jr, PhD.

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil

Empower Wellness

BIOPSYCHOSOCIAL CHILD ASSESSMENT

Please use Blue or Black Ink Only

Demographics

Client Name:	Date:
Current Address: City/State: Zip Code:	Phone #:
Date of Birth:	Marital/Relationship Status:
Ethnicity:	
Primary Language Spoken:	Secondary Language:
Referral Source:	Phone:
Emergency Contact:	Phone:

Family Relationships

Does the client have any children?					
Name	Date of Birth	Sex	Custody? Yes or No	Lives With?	Additional Information

Who else lives with the client? (Include spouses, partners, siblings, parents, other relatives, friends)				
Name	Age	Sex	Relationship	Additional Information
Primary Language of household/family:				Secondary Language:

Family History

Family History of (select all that apply):						
	Mother	Father	Brother/Sister	Aunt (maternal/paternal)	Uncle (maternal/paternal)	Grandmother/Grandfather (maternal/paternal)
Alcohol/Substance Abuse:	☐	☐	☐ ☐	☐	☐	☐ ☐
History of Completed Suicide:	☐	☐	☐ ☐	☐	☐	☐ ☐
History of Mental Illness/Problems Such as:						
Alzheimer's Disease/Dementia	☐	☐	☐ ☐	☐	☐	☐ ☐
Anxiety	☐	☐	☐ ☐	☐	☐	☐ ☐
Attention-Deficit/Hyperactivity	☐	☐	☐ ☐	☐	☐	☐ ☐
Bipolar Disorder	☐	☐	☐ ☐	☐	☐	☐ ☐
Depression	☐	☐	☐ ☐	☐	☐	☐ ☐

Incarceration	☐	☐	☐☐	☐	☐	☐☐
Learning Disorders	☐	☐	☐☐	☐	☐	☐☐
Schizophrenia	☐	☐	☐☐	☐	☐	☐☐
School Behavior Problems	☐	☐	☐☐	☐	☐	☐☐
Other:						

Client's/Family's Presentation of the Problem:
Client's/Family's Expected Outcome:

Physical Functioning

Allergies (Medication & Other):
Current Medical Conditions:
Surgeries:
Current Medications (include vitamins, herbs, and over-the-counter):
Past Psychiatric Medications:
Past Medical History including hospitalizations/residential treatment (list all prior inpatient or outpatient treatment including residential treatment centers, group homes, therapeutic foster care, aftercare, inpatient psychiatric hospitalizations, and outpatient medication treatment/therapy):

Dates:	Inpatient/Outpatient	Location	Reason	Completed? Y/N

During pregnancy, did your mother or if child (you) use any of the following (select all that apply)?

☐ TOBACCO	☐ ALCOHOL	☐ STREET DRUGS	☐ UNKNOWN

Comments (frequency and intensity of use, participation in treatment, birth defects or malformations due to drug/alcohol use among siblings?

Any problems labor and/or delivery? Apgar Scores?

Developmental Milestones- please select any that were done late or if patient is child, is still having trouble with:

☐ Rolling Over (2-6 months)	☐ Sitting (6-12 months)	☐ Standing (8-16 months)
☐ Walking (8-16 months)	☐ Engaging peers (24-36 months)	☐ Toileting (24-36 months)
☐ Dressing self (24-36 months)	☐ Feeding self	☐ Sleeping alone
☐ Tolerating Separation	☐ Playing cooperatively	☐ Speaking

Legal Status Screening

Past or current legal problems (select all that apply)		
☐ None	☐ Parole	☐ Probation
☐ Arrests	☐ Conviction	☐ DUI/DWI
☐ Jail	☐ Prison	☐ Detention Center
☐ Gangs	☐ Other	
If yes to any of the above, please explain: ☐ YES ☐ NO		

Child/Adolescent Educational Assessment

☐ Public	☐ College	☐ Charter	
☐ Private	☐ Home	☐Alternative	
☐ Technical College	☐ GED	☐ Other:	
Current grade level:	Skipped a grade:	Held back a grade:	
Any testing for an IEP (Individualized Education Plan)? ☐ YES ☐ NO			
History of/or current placement in special education? ☐YES ☐ NO			
For learning problems? ☐ YES ☐ NO For behavior problems? ☐ YES ☐ NO			
History of psychological testing? ☐ YES ☐ NO Comments:			
Ever been expelled or suspended? ☐ YES ☐ NO Reason:			
School attendance problems? ☐ YES ☐ NO Comments:			
Other education-related concerns:			

Psychological

History of Depressed Mood? ☐ YES ☐ NO If yes, were you professionally diagnosed by a psychiatrist and when? If no, what time period were you depressed?		
History of irritability, anger, or violence (tantrums, hurt others, cruelty to animals, destroy property):		
Sleep Pattern: Number of hours per day	Time to onset of sleep falling asleep	# of awakenings?
☐ Normal	☐ Sleeping too much	☐ Sleeping too little
Energy Level: ☐ Normal ☐ Low ☐ Average ☐ High		
Bereavement/Loss and Spiritual Awareness		
Please list significant losses, deaths, abandonments, traumatic incidents:		

Abuse/Neglect/Exploitation Assessment

History of neglect (emotional, nutritional, abandonments, traumatic incidents: If yes, please explain.
Has client been abused at any time in the past or present by family, significant others, or anyone else?

☐ NO ☐ YES, Explain:			
Type of Abuse	By Whom	Client's Age(s)	Currently Occurring? Y/N
Verbal putdowns			☐ YES ☐ NO
Being threatened			☐ YES ☐ NO
Made to feel afraid			☐ YES ☐ NO
Pushed			☐ YES ☐ NO
Shoved			☐ YES ☐ NO
Slapped			☐ YES ☐ NO
Kicked			☐ YES ☐ NO
Strangled			☐ YES ☐ NO
Hit			☐ YES ☐ NO
Forced or coerced into sexual activity			☐ YES ☐ NO
Other			☐ YES ☐ NO
Was it reported? ☐ YES ☐ NO		To whom?	
Has client ever witnessed abuse or family violence? ☐ No ☐ Yes, explain:			

Behavioral Assessment

Abuse/Addiction- Chemical and Behavioral				
DRUG	**Age First Used**	**Age Heaviest Use**	**Recent Pattern of Use (frequency, amount, how used)**	**Date Last Used**
Alcohol				
Cannabis				
Cocaine				
Stimulants (crystal, speed, amphetamines, etc.)				
Methamphetamines				
Inhalants (gas, paint, glue, whip its), etc.				
Hallucinogens, LSD, PCP, mushrooms, etc.				
Opioids (narcotics, heroin, methadone, suboxone, etc.)				
Sedative/Hypnotics (Valium, Xanax, Phenobarb., etc.				
Designer Drugs/Other (herbal, steroids, cough syrup, Kratom, etc.)				
Tobacco (smoke, chew, vape)				

Empower Wellness

General Patient Information

Please use Blue or Black Ink Only

Patient: _____ DOB: _____ Age: _____ S.S. #: _____

Email: _____ Sex: ___M ___F _____ Other (please specify)

Phone: _____ (C) _____ (H) _____ (W)

Address: _____ City & State: _____ Zip: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Marital Status (please circle): Married Single Separated Widowed N/A- Child

Employment Information

Company: _____ Phone: _____

Address: _____ City & State: _____ Zip: _____

Referral Information

Where or from whom did you hear of our services? _____

Primary Care Physician or Psychiatrist

Name: _____ Phone: _____

Guarantor Information (Skip unless patient is a minor)

Name of Guarantor: _____

Address: _____ City & State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Primary Insurance Information

Insurance Company: _____ Phone: _____

Address: _____

Policy ID#: _____ Group #: _____ Policy Owner's Name: _____

Policy Owner's Relationship to Patient: _____ Phone #: _____ DOB: _____

Policy Owner's Address: _____

Social Security #: _____ Authorization #: _____ Deductible: $ _____ Co-Pay: $ _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Address: _____

Policy ID#: _____ Group #: _____ Policy Owner's Name: _____

Policy Owner's Relationship to Patient: _____ Phone #: _____ DOB: _____

Policy Owner's Address: _____

Social Security #: _____ Authorization #: _____ Deductible: _____ Co-Pay: $ _____

Empower Wellness

Confidential Consent for Treatment

Please use Blue or Black Ink Only

Name: _____ **Social Security #:** _____ **Date:** _____

Explanation of Consent Form

This treatment consent form covers all procedures that are not of nature to require a special consent, i.e.: Medication Consent, Laboratory Consent, Animal Assisted Therapy and/or Court Services, and it provides protection for the procedures performed by the professional staff of Empower Wellness, LLC., hereafter "EW." This form documents that you are consenting to treatment with EW, including but not limited to, assessment and/or psychotherapy. We do not offer counseling services currently. Information about the specific services we provide has been given to you in writing and discussed with you. Your agreement to consent for services and signature on this form allows EW and their professional staff to provide services to you.

This form provides evidence that does not guarantee is made by any professional staff working with EW as to the outcome of treatment. There is no guarantee that treatment will be successful. This form also provides evidence that consent is given only after a full explanation has been provided by EW and/or their staff. If you have any questions concerning this or any other matters, it is your responsibility to ask EW. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form and supporting documents.

Consent to Treatment

I, _____ for _____

(Print your name) *(Print the patient's name, if minor)*

I do hereby voluntarily consent to care and treatment by the clinical staff of Empower Wellness, LLC. and/or their assistants and/or designees, hereafter "EW." I am aware that the practice of medicine, psychotherapy, and other therapy by a licensed professional is not an exact science, and I acknowledge that no guarantees have been made as to the result of evaluation or treatment.

I am aware that I am an active participant in the medication and psychotherapy process and that I share responsibility for treatment. My responsibilities in treatment include informing EW of any information that may be relevant to the problems or conditions being treated, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them. Children in joint legal custody must have both parents/guardians listed to be involved in treatment unless otherwise directed by a court of law.

This form has been fully explained to me and I certify that I understand its contents. I also understand that it is my sole responsibility to ask any questions or obtain any clarification necessary to my understanding this form fully.

Patient Signature: _____ Date: _____

Patient Guardian Signature: _____ Date: _____

Empower Wellness

Rules and Regulations

Please use Blue or Black Ink Only

Please Initial next to each item acknowledging that you read and understand the following:

_____ All copays and co-insurance monies are collected up front before seeing the Psychiatric Mental Health Nurse Practitioner.

_____ If I present a check that is returned unpaid for any reason, I will be charged a $30 fee on top of face value of the check and my check writing privileges to the office will be revoked.

_____ I understand that I must request any medication refills at least 48 hours in advance of needing them. I further understand that in order to receive my medications, I must be seen regularly as directed by the Psychiatric Mental Health Nurse Practitioner.

_____If I cannot keep a scheduled appointment, I will provide at least 24 hours' notice to the office. If I fail to notify the office within 24 hours of my scheduled appointment, I will pay the $25 for a no-show fee depended on your insurance and provider.

_____ I understand that this is not a pain specialist and does not provide pain management.

_____ I understand that the office has access to my prescription drug history on both a state level and National level and that information may be used in determining treatment or for continuity of care.

_____ I understand and authorize that staff may have access to my clinical history as provided by accessing through my health insurance provider.

_____If my insurance does not pay, I am responsible for the charge.

_____In the event a patient has incurred three (3) documented "no-shows" and/or "same-day cancellations," the patient may be subject to dismissal from Empower Wellness, LLC. The patient's chart is reviewed, and dismissals are determined by Dana Morgan, PMHNP-BC and/or Alicia Conn, PMHNP-BC, no exceptions, in accordance with Empower Wellness, LLC. guidelines.

_____ There is a $25 fee that is due prior to any letters that need to be written or filled out by the Nurse Practitioner. All forms including FMLA/Disability paperwork will be $75. Work related paperwork will not be filled out until three consecutive appointments have been met.

Empower Wellness

Your Rights as a Patient

Please use Blue or Black Ink Only

You have the right to ask questions about anything that happens in your medical and therapy treatment. EW professionals are always willing to discuss how and why they have decided to do what they are doing, and to consider alternatives that might work better. Additionally, as a patient of a Georgia Licensee you have the following rights:

- The right to be treated with consideration and respect for personal dignity, autonomy and privacy.
- The right to service in a respectful setting that offers the greatest possible freedom as defined in the treatment plan.
- The right to be kept up to date on current or suggested services, treatment or therapies, and of alternatives.
- The right to accept or reject any service, treatment, or therapy after you have been given a full explanation of the risks and benefits.
- The right to a current, written, individualized service plan addressing mental and physical health, social and financial needs, and describing who will provide these services and how they will be provided in a way that meets your needs.
- The right to active and informed participation in all areas of the service plan, including the plan's writing, review, and rewriting to meet your needs.
- The right to freedom from too much or unnecessary medication.
- The right to freedom from restraints or seclusion.
- The right to be informed of and to refuse any unusual or dangerous treatment procedures.
- The right to be told about and to refuse to be observed through one-way mirrors, photographed or taped (audio/visual).
- The right to absolute confidentiality unless court ordered or if you sign a Release of Information form permitting disclosure of all or part of your record.
- The right to see *all* parts of your records, including psychiatric and medical records. Access can be restricted *only* for clear treatment reasons, meaning that reading the records will cause you severe emotional damage resulting in the immediate risk of dangerous behavior toward yourself or someone else. Only specific parts of the chart can be restricted, with the reasons clearly documented in your service plan. However, you may give permission to *any person you choose* (friend, family member, advocate) to look at *all* parts of your records.
- The right to advance notice if a service is to be discontinued, and to be actively involved in planning to meet your needs when the service is discontinued.
- The right to have a clear explanation when any services are denied.
- The right not to be discriminated against in the provision of service on the basis of race, color, creed, religion, sex, national origin, age, lifestyle, physical or mental handicap, developmental disability, or inability to pay.
- The right to be fully informed of all rights.
- The right to exercise any and all rights without being threatened or punished in any way, including being denied services.

_____ _____

Signature Date

Empower Wellness

Release for Coordination of Care and Emergency Services

Please use Blue or Black Ink Only

In an effort to provide the best integrative care possible for our patients, Empower Wellness LLC. practices cross coverage for emergencies and utilize regular team supervision with our medical staff and in the future, therapy staff. Unless specifically restricted, your information will be accessible to other providers within our practice and to our practice management staff, on a need-to-know basis, to ensure smooth operations of office practices as well as clinical coverage for emergencies and case consultation for review and support.

Professionals with whom your protected information may be shared with include: our clinical and administrative staff and Dr. Shivers, Psychiatrist ----Medical supervisor (or any future medical supervisor who may contract with Empower Wellness, LLC.

Empower Wellness, LLC may send a notification to your family doctor or primary care physician informing him/her that you are receiving services from us. If you change to another physician during your care with us, please complete another form with the updated information.

The authorization can only be revoked upon giving us written notice.

Patients Name: _____ DOB: _____

Doctors Name: _____

Doctors Address: _____

City & State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

I acknowledge that my signature on this form gives my consent to Empower Wellness, LLC. and affiliated obtain from and release to the primary care physician listed above, all pertinent information associated with my treatment. I also acknowledge that my signature on this form gives my consent to Empower Wellness, LLC. to share information as outlined above for supervision, billing, scheduling, and coordination of care purposes.

Patient Signature: _____ Date: _____

Patient Guardian Signature: _____ Date: _____

Empower Wellness

Financial Policy

Please use Blue or Black Ink Only

Thank you for choosing our practice. Our goal is to provide excellence in integrative behavioral healthcare and customer service to you as our patient. Our financial policies are intended to help us accomplish our goal in a cost-effective manner in today's environment.

Insurance

- If you have an insurance that you want us to file, then you must present your insurance card at the time of your first visit and be ready to present at any subsequent visits if asked or if it changes. You will be asked to pay for your visit at time of services. If you do not want charges to go to insurance, do not give us any insurance information and pay in full at your visit.
- We will file claims to your insurance carrier and accept payment directly from them. It is your responsibility to keep us informed of any insurance coverage changes, regardless of whether it is primary or secondary. If you inform us incorrectly, and it causes timely filing denial, you will be responsible for any balance due. If your insurance company reimburses the patient per their policy, you will need to sign over the insurance check and the EOB or send us equivalent payment.
- If you are billed for denial of coverage, it is your responsibility to contact your insurance company regarding the denial, and you are responsible for all costs denied by the insurance if you failed to give us correct or timely information.
- We do not determine your copay, your coinsurance, or your deductible. **YOUR INSURANCE COMPANY DETERMINES WHAT WILL BE YOUR RESPONSIBILITY, IF ANY.**
- It is your responsibility to know your own insurance benefits, to know what providers are in your network. We will assist in filing but will not promise to know everything about your individual plan and are not responsible for any unpaid amount as a result of deductibles or denials from your insurance company.

Payment

- We accept payment via cash, personal checks, debit cards, or credit cards via Square App.
- If you do not have insurance, payment is due at time of service. If you do not have your insurance cards or if it cannot be verified, you may be asked to pay up to $100.
- Co-payments and outstanding account balances are due at time of service at check-in. Any other balance due per insurance company will be due within 2 weeks from receipt of your statement.
- We do not do payment plans; however, you can split your balance into two payments at checkout. Failure to comply and meet payment arrangements will trigger your account for review for collections and must be paid before your next visit.

Minors (Patients under 18 years old)

- The patient registration/intake form must be signed and guaranteed by a parent and/or legal guardian.
- We are unable to know the financial responsibilities of separated and/or divorced parents. The adult accompanying the patient is responsible for the payment and can make arrangements with the other parent at a later date and time.
- Minor consent form is available for completion by parent/guardian for future visits.

Labs

- Lab/urine/genesight/etc. that are ordered by our office are billed separately to your insurance by those companies. We are not affiliated and cannot assist you with questions about this bill.

Collecting Balances and Collections

- Balances are due within 2 weeks of statement receipt. You may be responsible for the collection agency commission if you are sent to collections for an old balance.
- Exceptions or special requests will require meeting with a financial/billing manager.
- Past due balances need to be paid prior to your next appointment. Overdue balances may be reviewed for collections review and if turned over to a collection agency, you may be dismissed from the practice.

I have been offered and I agree to Empower Wellness Financial Policy.

Signature: _____ Date: _____

Empower Wellness

Patient HIPAA Consent Form

Please use Blue or Black Ink Only

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. EACH PATIENT, OR GUARDIAN, SHALL BE REQUESTED TO REVIEW THE HIPAA PRIVACY CONSENT FORM PRIOR TO BEING SEEN.

OUR OBLIGATIONS:

We are required by law to:

- Maintain the privacy of protected health information (e.g., 18 items identifying "you")
- Give you this notice of our legal duties and privacy practices regarding health information about you.
- Follow the terms of our notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION: The following describes the ways we may use and disclose health information that identifies YOU ("Health Information"). Expect for the purposes described below for **Treatment, Payment, and Health Care**, we will use and disclose Health Information only with your written permission. You may revoke such permission at any time by writing to our practice Privacy Officer.

Our Notice of Privacy Practices provide information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our full Notice before signing this summary Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations.

BY SIGNING THIS FORM, you CONSENT to our use and disclosure of protected health information about you for treatment, payment, and healthcare options. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Empower Wellness, LLC. provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). ***If you have a POA or court order changing access by a parent or family member, please present a copy at check-in with signed form.***

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices posted and patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease information such as drug interactions and your prescription history.
- Parents of minor patients, regardless of marital status, have parental access unless legal paperwork stipulates otherwise.
- The Practice reminds patients about upcoming appointments via phone, voicemail, text, email, or mail.

Permission for Disclosures to Family Members and/or Friends (pick one)

___ 1) Only disclose my treatment and payment/account info to me.

OR

___ 2) You can also disclose my treatment and payment/account info to the following people listed:

a) _____ Relationship: _____
b) _____ Relationship: _____
c) _____ Relationship: _____

Please note that it is your responsibility to notify our practice in writing if you no longer desire to have your protected health information disclosed to a family member or friend that you have previously authorized and/or not listed as an exception.

Patient/Guardian Signature (printed): _____ Date: _____

Patient Guardian Signature & Relationship: _____ Date: _____

EMPOWER WELLNESS

Patient Agreement – Medication Monitoring Protocol

We understand that sometimes certain medications are necessary to provide an improved quality of life. This is an agreement between you and us, Empower Wellness, LLC (EW) regarding these medications. If it is decided to place certain medications into your regimen, it is important that you have a thorough understanding of these medications, including their expected benefits, side effects and potential(s) for becoming habit forming and their potential interaction with other medications and certain dietary components. We will do our best to work with you to find an appropriate medication and dosage regimen that makes you most comfortable while optimizing effectiveness. To that end and in accordance with State and Federal Medication Monitoring guidelines, we may perform a one-time Pharmacogenetic Test (PGx) for medication-sensitivity/tolerance/metabolizing, including over-the-counter (OTC), environmental, vitamin, herbal or holistic substances you might take now or in the future. This test may give us and any future doctor critical insight into exactly how your body transports and reacts to certain types of medications, enabling us to improve your care and tailor your prescriptions most effectively. We will also monitor medications by Urine Drug Screenings (UDT). Drug Screenings are done on the first three (3) visits, and then will happen at least quarterly (every 3 months) and, as often as monthly. Random screens will be taken of all patients as well.

Testing is intended to help those who:

- Appear difficult to treat as evidenced by therapeutic failure of previous medications.
- Have demonstrated sensitivity or lack of symptom relief with recommended dosage.
- Are on multiple medications which increases risk for adverse drug reactions.
- Have been non-compliant with medication regimen due to adverse drug reactions.
- Are experiencing unpleasant or intolerable side effects on their current medication regimen.
- Have a history of medication sensitivity and/or adverse drug reactions.
- Are being treated for the initial onset of a condition with no treatment history.
- Are a new patient.

All our efforts are intended to provide you with the best possible patient experience, to maximize treatment effectiveness and minimize potential side-effects. Once signed, you will be given a copy of this contract. A copy will remain in your file. If you have questions, feel free to ask.

_____ _____

Patient Signature Today's Date

_____ _____

Pharmacy you prefer Pharmacy Phone #

Empower Wellness

Good Faith Estimate for Mental Health/Counseling/Psychiatric services

Patient Information

First Name **Middle Name** **Last Name**

Date of Birth: _____ **Social Security Number:**_____

Patient Mailing Address/Phone Number/Email Address

Street/PO Box **Apartment**

City **State** **Zip Code**

Phone **Email Address**

Patient Contact Preference:

- **Mail**
- **Email**
- **Phone**

Primary Service(s) or Item Requested/Scheduled:

Mental Health/Counseling/Psychiatric Services; Individual, Family, and/or Couple.

*Provider/Clinician will determine diagnosis based on initial evaluation and follow-up sessions.

Date of Good Faith Estimate: _____

*The estimated cost is valid for 12 months from the date of The Good Faith Estimate. Any additional service(s) will be discussed with the and acknowledged by the patient and/or guardian.

Insurance Information

Initial for:

Filing insurance: _____ **Self-pay:**_____

Primary Insurance: _____

Member Policy Number: _____

Subscriber Name:_____

Subscriber DOB: _____

Provider Name:

Dana Morgan, APRN, FNP-BC, PMHNP-BC _____

Alicia Conn, APRN, FNP-C, PMHNP-BC_____

*See the attached itemized estimate of cost of services rendered including insurance and self-pay rates.

Estimated Total Cost for services

Ins=Insurance

SP= Self-Pay

Psychotherapy 16-30 min (initial apt): Ins: $ 155.00 SP: $100.00

Initial Psychiatric evaluation: Ins: $390.00 SP: $200.00

Follow-up evaluation and management: Ins: 99214-$250.00, 99213-$175.00, 99212-$110.00 SP: 99214-$125.00, 99213-$110.00, 99212-$100.00

Missed appointment: SP: $25.00

Paperwork completion: SP: $50.00 *depending on type of paperwork being requested to be completed.

Consultation notes: Ins: $70.00 SP: $50.00

Scales: Ins: $ 10.00 SP: $10.00

Injection: Ins: $ 27.00 SP: $20.00

In-house drug screen: SP: $25.00

Court subpoena: SP: $350.00-600.00 *amount subject to change depending upon requested/required services.

* "The Good Faith Estimate" shows the cost of services that are reasonably expected for you for a service being provided. The estimate is based on the relevant cost at the time the service is rendered. This estimate does not include any unexpected cost that may arise during treatment. You could be charged more if complications or special circumstances occur.

*All potential cost is not listed in estimate above. The charges listed above are the most common occurring charges.

*It is the responsibility of the patient to know the amount of co-pay (if insurance requires a co-pay), what the deductible is, if the deductible has been met, and if the insurance is active or not.

By signing below, I acknowledge that I have reviewed and agreed to the "Good Faith Estimate of Expected Charges" policy.

Patient(s)/Guardian(s) Name Printed:_____

Patient(s)/Guardian(s) Signature: _____

Date:_____

Empower Wellness, Inc.

1610 Alice Street

Waycross, Ga. 31501

912-584-3263 (office)

912-809-2296 (fax)

empowerwellness21@gmail.com

www.empower-wellness.org

Contact Person: Amy Shadron

Tax ID number: 86-1996857

EHR: Therapy Notes