INTAKE FORMS PACKET

Included in this Packet

1. **Patient Registration Form**
2. **Informed Consent- Bernadette Harned, PMHNP**
3. **Financial Responsibility**
4. **PHI Form**
5. **Arbitration Agreement**

Instructions

1. **Read, complete, sign and date the attached paperwork**
2. **Take to your appointment along with a copy of your Drivers' License and your Insurance Card**

26400 La Alameda, Suite 208, Mission Viejo, CA 92691
Ph~ 949.606.4698 Email~ bernadette.balancedhealth@gmail.com

PATIENT REGISTRATION INFORMATION

Patient's Last Name: ________________________Patient's First Name:_____________________________
Is this your legal name?: ______ If not, what is your legal name:_________________________________
Date of Birth:__________________Sex: M/ F Marital Status:____________________________
Full Home Address:____
Street City State Zip Code
Phone #: ______________________ Do you consent to receive automated reminder calls at this phone number? Y/ N
If Yes, please sign____
Full SSN: ________________________________

Email:________________________ Do you consent to allowing any/ all communication (medical &/or mental documentation, billing statements and financial information) being sent to the email address above? Yes Yes No

Emergency Contact: ______________________ Phone #: ________________________________
Relation to Patient:_______________________

Preferred Pharmacy: ____
Name Location Phone #

How did you hear about our clinic? ____

INSURANCE INFORMATION

(Please bring your Insurance Card & State ID/ Drivers' License to Office)

Person responsible for bill: _____________________________________DOB: _________________________
Address: ____Phone #: _______________________

PRIMARY INSURANCE

Insurance Company: _________________________
Subscriber's Name: __________________________
Subscriber's SSN: ___________________________
Policy #: _______________________________

Member/Subscriber ID:______________________
Relationship to Subscriber:__________________
DOB:_____________Co-payments $___________

Patient Signature: ______________________________________ Date: ___________________________

INFORMED CONSENT FOR SERVICES

Welcome to Balanced Health & Wellness. This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PROFESSIONAL FEES FOR MEDICATION MANAGEMENT (FINANCIAL POLICY)

The standard fee for the initial visit (without insurance) is $350.00, and each subsequent visit is $200.00. You are responsible for paying at the time of your appointment unless prior arrangements have been made. Any checks returned by your bank as non-payable are subject to an additional fee of $25.00 to cover bank fees that we incur. All accounts must be kept in a current status with no past due balance owing. If you refuse to pay your debt, we reserve the right to use an attorney/ collection agency to secure payment. BH&W has the right to charge $100.00 for missed (no show) or canceled appointments without 24 hours of notice *(sign below to acknowledge)*.

CONFIDENTIALITY & NOTICE OF PRIVACY PRACTICES

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. If you would like a complete copy of this, please ask at the front desk. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed clinical psychologist. In most situations, a psychologist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. However, there are some situations in which a psychologist may be permitted or required to disclose information without the patient's consent or authorization. These situations include:

1. If there is a reasonable suspicion or evidence that a child under age 18 is suffering or has been the victim of child abuse (including sexual and physical abuse, and neglect), the law requires that a report be filed with the appropriate governmental agency (Child Protective Services) and legal authorities. A report may also be made if we know or reasonably suspect emotional abuse of mental suffering inflicted upon a child.

2. We have reasonable suspicion or evidence that an elder or dependent adult is suffering or has been the victim of abuse (including sexual, physical, emotional and financial abuse, neglect, abandonment, abduction, isolation), the law requires that we report to legal authorities and/or the State Department of Social Services.

3. If a patient (or a family member of the patient) communicates an imminent threat of physical violence against an identifiable victim (the patient's intent to harm or plan to harm), we are required to take protective actions including notifying the potential victim (s), and contacting the police. We may also seek hospitalization for the patient.

4. If a patient communicates intent and/or a plan to harm himself/herself (commit suicide), we are required to notify legal authorities and make reasonable attempts to protect the patient including seeking hospitalization and notify family members who can help provide protection.

CONTACTING YOUR PROVIDER

Your provider may not always be immediately available by telephone. They will not answer their phone when they are with clients, outside of normal business hours, or otherwise unavailable. At these times, you may leave a voice mail on the office phone (949-606-4698) or send an email *(bernadette.balancedhealth@gmail.com)* and your call/ email will be returned as soon as possible for non-urgent matters. If you feel you cannot wait for a return call or email, or if you feel unable to keep yourself safe, go to your local Hospital Emergency Room or call 9-1-1 and ask to speak to the mental health professional available.

PRESCRIPTION REFILLS

Please call your pharmacy to request refills. Those requests will be forwarded to our office for approval. Patient compliance is required to continue receiving your prescribed medications & appointments might be necessary in order to refill your medications.

I understand that I may request & be given a copy of the NOTICE OF PRIVACY PRACTICES- Psychology & Psychiatry Services.

I understand if I have questions about this notice, disagree with a decision made about access to my records, or have other concerns about my privacy rights, I may contact Balanced Health and Wellness at 949-606-4698.

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

____

Signature of Patient/ Representative

I understand & acknowledge BH&W policy regarding missed appointments & outstanding balances.

____

Printed Name of Patient/ Representative

____

Date

FINANCIAL RESPONSIBILITY

Balanced Health and Wellness participates with most major health plans and will accept payment directly from them. As a courtesy to you, we will send claims in to your primary, and secondary carriers, if necessary. However, it is important that you understand your insurance policy and that benefits are an arrangement (contract) between you and your insurance company. You are personally responsible for all allowable fees as directed by your insurance company, as well as non-covered services that you have agreed to. These fees are usually categorized as a Copay, a Co-Ins (percentage), or a Deductible. Certain insurance plans will authorize a specific number of visits for a certain period of time. Please be certain that you are aware of your benefits, as you will be personally liable for any visits that fall outside of that scope, and are denied by your plan. When in doubt, please verify this information with your insurance company. ***Additionally, please be aware that all correspondence regarding your claims will be sent to the subscriber on record of your insurance policy.*** Our staff will make their best effort to verify insurance eligibility and benefits, but ultimately it is the patient's responsibility to know their policy and coverage. All patients that present without valid insurance information will be considered a Self-Pay Patient. You are required to pay all patient responsibility portions at the time service is rendered, unless prior arrangements have been made.

Credit Card Authorization Form

Credit Card Number: ____
Expiration Date: _________________________ CVV: ______________________
Name on Card: ____
Billing Address: ____

I, ________________________________, authorize Balanced Health and Wellness to charge the above referenced credit card for missed or canceled appointments without 24 hours of notice ($100), any letters or other administrative paperwork I request (fee TBD), other fees and services that are not covered by my insurance policy.

I have read and understand Balanced Health and Wellness' financial responsibility agreement.

By signing below I acknowledge that in order to make future appointments at Balanced Health and Wellness, I must have a form of payment on file.

______________________________ ______________________________
Patient Printed Name Patient Signature, if of legal age.

____
Date

______________________________ ______________________________
Parent/Guardian Printed Name Parent/Guardian Signature

Permission to Verbally Discuss Protected Health Information

Patient name	Date of birth			
Patient street address	City		State	Zip
Home phone	Work phone			

I give permission to Balanced Health and Wellness to VERBALLY discuss the following medical and billing information about me *(check all boxes that apply)*. YOU MUST CHECK AT LEAST ONE.

- ☐ Scheduling/Appointment information
- ☐ Medical information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information, including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ **I DO NOT WANT ANY INFORMATION RELEASED TO ANYONE**

Balanced Health and Wellness has my permission to discuss the above information with:

1 Name ______________________ Relation to patient: ____________

Home phone ____________ Work phone ____________

2 Name ______________________ Relation to patient: ____________

Home phone ____________ Work phone ____________

3 Name ______________________ Relation to patient: ____________

Home phone ____________ Work phone ____________

I understand that I have the right to revoke my permission at any time except where Balanced Health and Wellness has already made disclosures in reliance upon this request. **I understand that I must notify Balanced Health and Wellness in writing if I want to revoke my permission.**

Date ____________

Signature of Patient/Authorized Representative X ______________________

If authorized representative, please sign and attach copies of supporting legal documentation.

Reason patient unable to sign ______________________

NOTE: For copies of medical records, contact Balanced Health and Wellness.

—Information sheet on back—

Permission to Verbally Discuss Protected Health Information

Balanced Health and Wellness knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?

Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?

No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our office, or by calling Balanced Health and Wellness.

What if I change my mind?

You can change or revoke (stop) this process at any time by writing to us at the address shown below, or by calling 949-606-4698.

What happens if I don't complete this form?

We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?

Mail to:

Balanced Health and Wellness
26400 La Alameda, Suite 208
Mission Viejo, CA 92691

Call 949-606-4698 with questions.

PATIENT NAME:

ARBITRATION AGREEMENT

Article 1: Agreement to Arbitrate: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as state and federal law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: All Claims Must be Arbitrated: It is also understood that any dispute that does not relate to medical malpractice, including disputes as to whether or not a dispute is subject to arbitration, will also be determined by submission to binding arbitration. It is the intention of the parties that this agreement bind all parties as to all claims, including claims arising out of or relating to treatment or services provided by the health care provider including any heirs or past, present or future spouse(s) of the patient in relation to all claims, including loss of consortium. This agreement is also intended to bind any children of the patient whether born or unborn at the time of the occurrence giving rise to any claim. This agreement is intended to bind the patient and the health care provider and/or other licensed health care providers or preceptorship interns who now or in the future treat the patient while employed by, working or associated with or serving as a back-up for the health care provider, including those working at the health care provider's clinic or office or any other clinic or office whether signatories to this form or not.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the health care provider, and/or the health care provider's associates, association, corporation, partnership, employees, agents and estate, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress, injunctive relief, or punitive damages.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days thereafter. The neutral arbitrator shall then be the sole arbitrator and shall decide the arbitration. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees, witness fees, or other expenses incurred by a party for such party's own benefit.

Either party shall have the absolute right to bifurcate the issues of liability and damage upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity that would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that provisions of the California Medical Injury Compensation Reform Act shall apply to disputes within this arbitration agreement, including, but not limited to, sections establishing the right to introduce evidence of any amount payable as a benefit to the patient as allowed by law (Civil Code 3333.1), the limitation on recovery for non-economic losses (Civil Code 3333.2), and the right to have a judgment for future damages conformed to periodic payments (CCP 667.7). The parties further agree that the Commercial Arbitration Rules of the American Arbitration Association shall govern any arbitration conducted pursuant to this Arbitration Agreement.

Article 4: General Provision: All claims based upon the same incident, transaction or related circumstances shall be arbitrated in one proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable legal statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence.

Article 5: Revocation: This agreement may be revoked by written notice delivered to the health care provider within 30 days of signature and if not revoked will govern all professional services received by the patient and all other disputes between the parties.

Article 6: Retroactive Effect: If patient intends this agreement to cover services rendered before the date it is signed (for example, emergency treatment) patient should initial here. _______. Effective as the date of first professional services.

If any provision of this Arbitration Agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision. I understand that I have the right to receive a copy of this Arbitration Agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

PATIENT SIGNATURE **X** (Date)

(Or Patient Representative) (Indicate relationship if signing for patient)

OFFICE SIGNATURE **X** (Date)

ALSO **SIGN** THE **INFORMED CONSENT** ON **REVERSE** SIDE