kaleidoscope Health

Kaleidoscope Health, LLC
Dr. Matthew Appling, DNP, APRN, PMHNP-BC
om@kaleidoscopementalhealth.com
770.568.6061 / 954.699.0790

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, employee review of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclosure your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors. And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required uses and disclosures; under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

SIGNATURE REQUIRED ON OTHER SIDE

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Your rights

Following is a statement of your rights with respect to your protected health information.
You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.
You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,
upon request, even if you have agreed to accept this notice alternatively i.e. electronically.
You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
You have the right to receive an accounting of certain disclosure we have made, if any, or your protected health information.
We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.
Complaints
You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.
We will not retaliate against you for filing a complaint.
This notice was published and become effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Signature of Patient/Power of Attorney/Guardian

_____

_____ _____

Printed Name of Patient **Date**

_____ _____

Signature of Witness **Date**

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HIPAA Privacy Notice & Consent for Services Signature Form

I have received my Notice of Privacy Practices which informs me how my medical information may be used and released. This form also grants permission to Dr. Matthew Appling, DNP, APRN, PMHNP-BC (Psychiatric Mental Health Nurse Practitioner) to see the patient for initial and/or follow up visits and medication management. I understand that we are under no obligation and may revoke services at any time.

_____
Signature of Patient/Power of Attorney/Guardian

_____ _____
Printed Name of Patient **Date**

_____ _____
Signature of Witness **Date**

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PATIENT FINANCIAL POLICY

Thank you for choosing Kaleidoscope Health as your mental health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. It is your responsibility to notify our office of any patient information changes (i.e., address, name, insurance information, etc.).

Co-pays

The patient is expected to provide an insurance card at the first visit or when insurance information has changed. All co-payments and past due balances are due at time of the visit unless previous arrangements have been made with our office. We accept most major credit cards.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. the insurance company makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately.

Outstanding Balance Policy

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, and possible discharge from the practice. In the event an account is turned over for collections, the person financially responsible for the account will be responsible for the principle balance plus 25% collection fee. court and attorney fees. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

There will be a $125.00 fee for no call/ no show or cancellations of appointments. To avoid this fee please contact the office to reschedule your appointment 24 hrs prior to scheduled appointment.

_____ _____

Signature of patient or responsible party Date

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CLIENT TEXT MESSAGE CONSENT FORM

_____ _____
CLIENT NAME CLIENT PHONE NUMBER

By signing this form I Agree to receive text messages with appointment confirmation from Kaleidoscope Health, Reply STOP to opt out. reply HELP for Help. Messages frequency varies. Messages and date rates may apply. Carries are not liable for delayed or undelivered messages.

_____ _____
CLIENT SIGNATURE DATE

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PATIENT INFORMATION SHEET

LEGAL NAME: _____ _____ ____
Last **First** **MI**

DOB: _____ **Telephone Number:** _____

Address: _____

City_____ **State** _____ **Zip Code**_____

Email: _____

required for billing purposes

***Social Security#**_____

***Primary Ins**_____**ID#**_____**Group**_____

***Secondary Ins**_____**ID#**_____**Group**_____

Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widow/Widower**

If married, name of Spouse: _____

Spouse's Social Security Number: _____ **DOB:** _____

Name of physician/person that referred you: _____

Address: _____**Phone:** _____

Employment Status: (***Please check one)***

☐ **Retired** ☐ **Disabled** ☐ **Employed**

Pharmacy name/phone_____

Pharmacy address _____

Is patient in an assisted living facility, personal care home or nursing home? _____

If yes, what is the name of the facility? _____

Facility Telephone Number _____

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If other than patient, to whom should all correspondence be mailed?

Name:_____ Address: _____

City_____ State ____ Zip _____ Phone: _____

Email: _____

Relationship to patient: _____ Power of Attorney? Yes No

(Please provide a copy of the power of atty. for the chart)

****The power of attorney will be contacted first for all matters. If there is no power of attorney we will contact the person named above for all matters. In the event the patient, primary contact named above or power of attorney cannot be reached, please provide the name of another person that we may contact in case of an emergency.***

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home phone_____ Work phone _____ Cell _____

Release for billing

By signing below you give us authority to release any medical information deemed necessary to the appropriate insurance company in order to bill for your medical services. You also agree to accept full responsibility for any balances or co-pays that are not covered by your primary and/or secondary insurance company.

Signature: _____

(Patient or Power of Attorney)

Printed Name of Patient: _____

DATE: _____

Please Attach a copy of all insurance cards (front and back) and a copy of driver's license.

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PRE-VISIT FORM

Last Name	First name	MI	AGE	DOB

Referred by:	Name & phone number of Primary Care Physician:

Marital Status: □ Single □ M-Married □ W-Widowed □ D-Divorced	Spouse's Name	Years Married

# of Children:	# of Grandchildren:
Child Name:	Phone #:
Child Name:	Phone #:

Where were you born and raised?	Where do you currently reside?

Highest level of education completed: □ Primary School □ Secondary School □ High School □ College □ Advanced degree

Occupation:	Retired: Y or N Year retired:

Do you have special living needs? Y or N
If yes, please explain

Are you disabled? Y or N
If yes, please describe

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HEALTH HISTORY

Reason for visit: please do not leave blank	Allergies:
Do you have a memory problem? Y or N If yes, please explain	Do you smoke? Y or N Packs per day? If you quit, when did you stop?
Do you have a Psychiatric History? Y or N If yes, please describe	Do you drink alcohol? Y or N If yes, how often? If you quit, when did you stop?
Has anyone in your family had memory or emotional problems? Y or N If yes, please describe	

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PAST MEDICAL HISTORY

□ Rheumatic Fever	□ Diabetes	□ Diarrhea
□ Heart Attack	□ High Blood Pressure	□ Kidney Disease
□ Congestive Heart Failure	□ Cataracts	□ Asthma/COPD
□ Irregular Heart Beat	□ Glasses	□ Seasonal Allergies
□ Dizziness	□ Hearing difficulty	□ Thyroid Disease
□ Ankle Swelling	□ Ulcer	□ Liver Disease
□ Shortness of Breath	□ Anemia	□ Arthritis
□ Stroke	□ Urinary Tract Infection	□ Other
□ TIA's	□ Prostate Problems	
□ Head Injury	□ Cancer	
□ Loss of Consciousness	□ Constipation	

FAMILY HISTORY					
Pathology	Relationship	Pathology	Relationship	Pathology	Relationship
Alcoholism		Cancer		Glaucoma	
Asthma		Diabetes		Heart Dz	
Bleeding Dz		Seizures		Hypertension	
Kidney Dz		Mental Illness		Migraine	
Osteoporosis		Stroke		Thyroid Dz	

Year of most recent					
Tetanus Shot		Cholesterol √		Pneumovax	
Flu Vaccine		Rectal Exam		TB Test	
PSA		Mammogram		Colonoscopy	

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PAST MEDICAL HISTORY

Past Hospitalizations	
Year	Reason

Past Surgical History	
Year	Surgery

Current Medications