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: _____ Cel.: _____

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

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 David Faulk, Psychiatrist ----Medial 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 you're 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. <u>YOUR INSURANCE COMPANY DETERMINES WHAT WILL BE YOUR RESPONSIBILITY, IF ANY.</u>
- 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 case, 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, whether collected at check-in or check-out. 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 other parents at a later date and time.
- Minor consent form is available for completion by parent/guardian for future visits.

Labs

- Lab services ordered by our office are billed separately to your insurance by those companies.

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

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 Thrift, APRN, FNP-C, PMHNP-BC_____

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

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 #

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: $197.00

Follow-up evaluation and management: Ins: 99214-$250.00, 99213-$175.00, 99212-$110.00 SP: 99214-$123.50, 99213-$110.00, 99212-$100.00

Missed appointment: SP: $50.00

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, 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.

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912-584-3263 (office)

912-809-2296 (fax)

empowerwellness21@gmail.com

www.empower-wellness.org

Contact Person: Allison Harrison

Tax ID number: 86-1996857

EHR: Therapy Notes