MERCY PSYCHIATRY CLINIC

Address: 4941 Golden Triangle Blvd. Ste 911
Fort Worth, TX 76244
Email: mercystaff@mercypsychiatrys.com
Office Phone: 817-779-3716
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New Patient Forms

Basic Information

Full Name
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Other **Date of Birth** _____/_____/_____

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Email _____ **Social Security Number** _____

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Marital Status _____ **Maiden Last** _____

Driver's License State _____ **Driver's License #** _____

Demographics

Sexual Orientation _____ **Gender Identity** _____

Hispanic or Latino? _____ **Ethnicity** _____

Race _____ **Language** _____

Emergency Contact

Relationship to Contact _____

Full Name
First Middle Last Suffix

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Email _____

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Financial Information

Responsible Party

Who will be financially responsible for you? ◯ Myself ◯ Someone Else

If you chose "Someone Else", please fill out the following:

Relationship to Contact _____

Full Name
First **Middle** **Last** **Suffix**

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Method of Payment

What will be your method of Payment? ◯ **Insurance** ◯ **Self-Pay**

If you chose "Insurance", please fill out the following:

Primary Insurance Policy

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____

City _____ **State** _____ **Zip** _____

Relationship to Primary Policy Holder _____

If you are not the primary policy holder, please fill out the following:

Full Name
First Middle Last Suffix

Sex ◯ Male ◯ Female ◯ Other **Date of Birth** _____/_____/_____

Primary Phone ◯ Home ◯ Mobile ◯ Work **Phone Number** _____

Email _____ **Social Security Number** _____

Address Line 1 _____ **Address Line 2** _____

City _____ **State** _____ **Zip** _____

Secondary Insurance Policy

If you do not have a secondary insurance policy, you can leave this blank.

Insurance Company _____ **Policy Number** _____

Insurance Plan _____ **Insurance Phone Number** _____

Group Number _____

Insurance Company Address _____

City _____ **State** _____ **Zip** _____

Additional Information

Please list your preferred pharmacies in order of preference

Pharmacy Name	**Pharmacy Address**

How did you hear about us? _____

Practice Information

Patient's Rights:

As a Patient, I have the right to

- Be accurately informed of clinic policy and procedures.
- Special accommodations due to a disability or language barrier.
- Participate in decisions about my care.
- To decline any or all treatments.
- Receive a fair and objective review of any complaints I express regarding the level of care or service received.

Patient's Responsibilities As a Patient, you are responsible for:

- Recognizing that there are risks and limitations that may arise while providing medical services and understanding that the clinic teams act in the best interest of you.
- Adhering to all safety policies and regulatory protocols while on the clinic property and when interacting with staff.
- Showing respect for others, including the treating provider, support, management staff,
- Disclosing relevant, accurate, and complete information about your health
- Clearly communicating your wants and needs before, during, and after an appointment and using the appropriate client feedback processes to address any concerns that may arise.
- Following administrative and operational procedures and policies including but not limited to observing scheduling and visiting hours payment of services and policies.
- Recognizing that there are risks and limitations that may arise in the course of providing medical services and understanding that the clinic teams act in the best interest of you.
- Adhering to all safety policies and regulatory protocols while on the clinic property and when interacting with staff.

Acknowledgement of The Receipt of Mercy Psychiatry's Notice of Health Information Practices

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing and arranging your medical care.
Mercy Psychiatry is furnishing you with the attached notice, which provides information about how Fusion Family Consulting and its providers may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. By signing this form, you acknowledge that you have received a copy of Mercy Psychiatry's Notice of Health Information Practices

Practice Policy

Thank you for choosing Mercy Psychiatry for your health care needs. We look forward to working alongside you for your psychiatric care. As part of your relationship with Mercy Psychiatry, clear comprehension of our office policy is vital. This will help you understand office procedures, individual responsibilities, financial liability, and the extent and limits of various forms of communication. These policies may be updated over time, for which you will be notified.
Please review these carefully and ask any questions you may have. We are asking that you sign the bottom confirming that you have read them and understand.

Treatment Participation

Your treatment with us may involve undergoing evaluation, medications, and or engaging in various therapy treatments. If your treatment involves medication, your provider will explain the critical risks, benefits, and side effects to you. If unexpected side effects are experienced upon taking medications, please call the office immediately.

Confidentiality

Anything you reveal in your sessions is confidential and cannot be released to another person without your consent. Exceptions to this rule of confidentiality occur when the provider reasonably believes that there is an imminent risk of harm to yourself or another person or if a judge requests information as part of a trial. Also, if we are filing to your insurance company, diagnosis codes are sent, and insurance may request medical records to process your claims.

Phone Calls

Regular brief phone calls made between the hours of 8:30 a.m. and 5:00 p.m. on weekdays will be returned as quickly as possible; calls will typically be returned the same day. Routine calls received after 3:00 p.m. or on weekends will be returned the following business day. If the call involves an urgent matter, please convey this when leaving your message. If the reason for the call is an emergency, please do not hesitate to go to the nearest emergency room or call 911.

Appointments

Patients can request appointments by telephone or through the patient portal. Dates will be confirmed by phone ahead of time; however, it is the patient's or guardian's responsibility to keep track of the appointment to avoid charges for missed or canceled appointments.
If a patient arrives late to an appointment, it can be disruptive to other patients. The provider may cancel and reschedule the appointment if the patient is more than 15 minutes late to their appointment. The patient will be subject to the full charges of the appointment, and these charges cannot be billed to insurance.
All appointments are scheduled per hour. Please note that most insurance companies will only allow 1hr session per visit. Should the visit go over the scheduled time and the insurance deems the prolonged service a non-covered service, the patient will be financially responsible for the remaining balance.

Appointment Changes/Cancellations

Patients will be charged a rate of $75 when cancellations occur unless notice is given at least 24 hours before the appointment. This fee will need to be paid in full before future service is provided.
If for any reason, the doctor must cancel an appointment, the patient will be advised in advance.
Providers are only allowed to cancel appointments for patients on the same day due to a clinical or personal, unforeseen emergency.
After three consecutive missed appointments within one calendar year, the provider may dismiss a patient from Mercy Psychiatry due to treatment noncompliance.

Telemedicine Policy

For more extensive phone calls, please schedule a phone appointment with your physician. There will be a routine charge per hour for these phone sessions based on the time spent per call. Please note that most insurance companies will not reimburse phone consultation/sessions fees.

Charges & Payments

- Payment for services is due at the time of service.

CASH or CREDIT CARD (Visa, MasterCard, & Discover) are the only acceptable forms of payment (please bring exact change as Mercy Psychiatry does not carry cash).

- If the medical bill is 30-60 days past due, this account will be transferred to a collections agency, and all debt collection expenses will be added.

Credit Card on File Policy

For the convenience of the patient, Mercy Psychiatry requires keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance doesn't cover, but for which you are liable.
Your credit card information is kept confidential and secure, and payments to your card are processed after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account.

Electronic Mail (Email) Policy

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, fax, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we would caution you against emailing anything of a very private nature or personal information. Additionally, your doctor will save your email correspondence, and these communications should be considered part of your medical record. Therefore, you should think that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature. Your doctor will make an effort to check your email regularly; however, please call our office if you have not received a reply within 72 hours.

Medication Refill Policy

Refills should be requested through your pharmacy. They can fax a request to (817) 506-3716. If a request is made by phone, you will be informed to contact your pharmacy. Please ensure that you reach your pharmacy at least 72 hours before your medication runs out.
Prescriptions may only be refilled for patients who are current patients and who maintain their regularly scheduled appointments. For your safety, medication refills will not be called in over the weekend except in emergencies.

Medication refills will NOT be performed in the following cases:

- After office hours (including possibly late Friday afternoon requests) or over the weekend
- During holidays
- For patients who repeatedly miss appointments
- If there is suspicion of abuse of medications or failure to comply with urine drug screen requirements

Prior Authorizations

Mercy Psychiatry will perform prior authorizations; however, it is essential to understand that these authorizations do take several days to be approved. Please contact your insurance as well if you know your services require prior approval.

Additional Requests

Our providers do not testify in court, but if legal actions occur in which we are requested or subpoenaed to provide testimony (such as a Guardianship case), you will be responsible for providing the following even if the subpoena is sent from the opposing side of the case and even if your ongoing relationship with the provider has ended:

- Travel expenses.
- Hourly or per diem fees are based on the provider's then-current session rates, plus 50% of that fee from when the provider leaves her office until their return.

If the provider is needed to travel to an out-of-office consultation, such as assisted living, charges are billed at 150% of the in-office fee and include travel time.

FMLA/Temporary Absence Paperwork:

FMLA or temporary absence paperwork WILL NOT be filled out until the patient has been under care for 120 days. Patients requesting FMLA or temporary absence forms to be filled will have a $120 paperwork fee cost per form requested.
Thank you for going through this important information. We look forward to working with you. The Practice policies were updated on 01/08/2022 and are subject to change at the discretion of Mercy Psychiatry Inc.

_____ _____

Patient Signature Date

Credit Card Authorization

Our office requires that a credit card be kept on file for payment of any co-payment, coinsurance, deductible or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to this information.

Patient Name _____

Name as it appears on card: _____

Type of Card: Mastercard Visa American Express Discover

Card Number: _____

Expiration Date: _____ CVC Code (3 Digit Code): _____

I acknowledge and authorize Mercy Psychiatry to charge the above credit card for any copayment, coinsurance, deductible or charge that is not covered by my health insurance. I acknowledge that my card will be run in the event: payment is not received within 30 days after receiving a statement. I agree to receive billing statements, invoices, and receipts. If I am an uninsured patient, I authorize payment at the time of service. I agree to update any information regarding this credit card account if needed.

_____ _____

Patient or Guarantor Printed Name Patient or Guarantor Signature

_____

Date

Consent to Treat

The Health Insurance I hereby authorize employees and agents of Mercy Psychiatry (including physicians, physician assistants and nurse practitioners and other employees and staff members) to render mental health evaluations and care to the patient indicated below. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent the patient will not be provided mental health care.

_____ _____

Patients Name Date of Birth

_____ _____

Patients Signature Date

_____ _____

Guardian's Signature (if patient has guardian) Date

Financial Responsibility

I hereby authorize payment of medical mental health benefits directly to Mercy Psychiatry and or the attending physician for services rendered. Authorization is hereby granted to release information contained in patients medical record to patients' medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that this authorization may include the release of information regarding communicable diseases such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered, which may include services not covered by the patient's insurance companies. I agree that all the amounts are due upon request and are payable to Mercy Psychiatry. I further understand that should my account become delinquent, I shall pay the reasonable attorney fees or collection expenses of Mercy Psychiatry if any. The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____

Patients Name Date of Birth

_____ _____

Patients Signature Date

_____ _____

Guardian's Signature (if patient has guardian) Date