Integrity Mental Health Services LLC

2320 Drusilla Lane, Ste. A #1220 Baton Rouge, LA 70809

Phone: 225-328-5551 Fax: 225-230-1046

Email: Integritymentalhealthservices@mdofficemail.com

PATIENT REGISTRATION: Please attempt to answer all questions.

Full Legal Name: Last: _____ First: _____ MI: A_____

Date of Birth: _____ Gender: Male / Female Ethnicity: _____ Social Security # _____
Home Address: _____

City: _____ State: _____ Zip Code: _____ Home Phone:_____ Cell Phone:_____

Email:_____ Preferred method of contact: Text/Call_____

Occupation:_____ Employer:_____

Do you give us permission to leave "call back" messages on your voicemail? YES NO

GUARANTOR/ PERSON RESPONSIBLE FOR PAYING THE BILL

First: _____ Last: _____ MI:_____

Home Address: _____

City/State/Zip: _____ Home phone:_____ Cell:_____

Email: _____ Preferred Method of Contact:_____

Insurance Payer: _____Policy #_____Group #: _____

Address: _____ City:_____ State: _____ Zip code: _____

EMERGENCY CONTACT INFORMATION

CONTACT #1 Name: _____

Relationship: _____ Cell Phone: _____

Home Phone: _____

CONTACT #2 Name: _____ Cell Phone: _____

Relationship: _____ Home Phone: _____

Patient signature: _____ Date: _____

Patient representative name: _____ Relationship to patient: _____

Representative Signature: _____ Date_____

Health Questionnaire

PATIENT NAME: _____ Date of Birth: _____ Date: _____
Reason for visit: _____

ALLERGIES: Are you allergic to any drugs/food? If yes, please list them below along with reactions.

Medical History:

Please check to indicate if you have ever had the following conditions:

__Thyroid disease
__Diabetes – Type I or II
__Heart attack
_Coronary Artery Disease
__Arrhythmia / Palpitations
__Congestive Heart Failure
__High Cholesterol
__High blood pressure
__Vertigo/Dizziness
__Seizures
__Stroke
__Migraine Headaches
__Cancer, type_____

__Arthritis/Bursitis
__Osteoporosis
__Gout

__ Emphysema / COPD
__Tuberculosis
__Asthma
__Anemia
__Constipation/ Diarrhea
__Hepatitis
__Intestinal Problems
__Incontinence
__GERD / Gastritis
__Liver Disease
__kidney disease

Other_____

Psychiatric History:

Please check to indicate if you have ever been diagnosed with any of the following conditions:

__ Depression
__ Anxiety
__ Schizophrenia
__ Bipolar disorder
__ ADHD
__ OCD
__ eating disorder (Specify type) _____
__ Insomnia
__ Personality disorder
__ Cutting or self-harming behaviors

Other: _____

Have you ever been hospitalized in a mental health hospital?
Date: Facility name: Reason for Treatment:

_____
_____
_____
_____

Have you ever attempted suicide? Yes/ No No
Number of suicide attempts: 0_____

Surgical History:

Please indicate any surgeries or hospital stays you have had and their approximate date/year:

__Angioplasty / Stents
__Appendectomy
__Hysterectomy
__Heart Valve Replacement
__Hernia Repair
__Hip Replacement
__ Coronary Bypass
__Gallbladder
__ Pacemaker / Defibrillator
__ Back or Neck
__Mastectomy R or L

Other surgeries: _____

Primary Care Provider: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip code: _____

Other specialists or medical providers: _____

History:

Do you smoke or use any tobacco products? Yes, No Quit ___ How long ago? ___ Number of cigarettes each day? _____ How many years? _____
Other forms of tobacco used? _____
Do you drink alcohol? Yes, No Quit How much: _____ How Often:_____
Have you regularly used other drugs? Yes No If yes, are you still using them? Yes / No

Name of drug: How much do you use: Frequency of use: Last use:

_____
_____
_____
_____
_____
_____----_____

Do you live alone? Yes No Who lives with you at home?_____
Are you sexually active? Yes No With Men Women Both
Have you ever been pregnant: Yes No How many times: ____ Number of live births: ____
How many miscarriages: ____ How many abortions: _____ C-sections: _____
Do you use any form of birth control? Yes No If yes, which type / brand:_____
Do you have menstrual periods:_____ Yes No
If no, at what age did they stop: _____ If yes, are your periods regular:____
Highest Level of education: _____ Marital Status: _____ Employment:_____
Ever been arrested: _____ Chemical/ Drug use: _____ Smoker: _____

Family History:

Please indicate if there is a family history of any of the following conditions and the relative with the condition:

Name: _____

↑ or ↓ and AGE **Check any of the diseases that run in your family and please note who:**	None	Mother	Father	Sister	Brother	Grandmother (Mother's Side)	Grandfather (Mother's Side)	Grandmother (Father's Side)	Grandfather (Father's Side)	Child
Alcohol or Drug Use										
Cancer / Type										
Diabetes										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Mental Illness										
Osteoporosis										
Stroke										
Alzheimer's Disease										
Thyroid Disease										
Other:										
Other:										
Other:										

Integrity Mental Health Services
2900 Westfork Ave. Suite 401 Baton Rouge, Louisiana 70827
Phone: 22-328-5551 Fax: 225-230-1046 Email:
Integritymentalhealthservices@mdofficemail.com

Patient Name: _____DOB: _____
Current pharmacy:_____ Location (zip code required:_____
Phone:_____ Allergies:_____ Weight:_____ Ht: _____
Please list all medications that you are taking below, including vitamins and herbal supplements.

Medication	Dosage (	Route (by mouth, shot)	Frequency (how often do you take the medication)	Last date taken?

Integrity Mental Health Services LLC

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Consent for Telehealth Services

I understand that my healthcare provider wishes me to engage in telehealth services. My health care provider explained to me how the video conferencing technology will not be the same as a direct client/ health care provider visit because I will not be in the same room as my provider. I understand that telehealth has potential benefits including easier access to care and the convenience of meeting from a location of my choosing. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that the healthcare provider or I can discontinue the telehealth visit if it is felt that the videoconferencing connections are not adequate for the situation. I have had a direct conversation with my provider, during which I had the opportunity to ask a question regarding this procedure. My questions have been answered and the risks, benefits, and any practical alternative have been discussed with me in a language in which I understand.

Privacy and Release of Information

(Please initial where indicated)

Our practice values and upholds the importance of your confidentiality. In addition to your rights as a patient, our practice has duties to protect your confidential information and inform you of changes to protection measures. We are required by law to maintain the privacy of confidential information and provide you with notice of our legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect. There are, however, certain situations in which we must, by law, communicate your confidential information. Here is a list of those circumstances:

- We have reason to believe you are a danger to yourself or another person or persons
- We become aware of abuse to children, elder, or developmentally disabled person
- We are under court order to release information
- Subpoena of treatment records by an attorney. (We will not immediately release records upon receipt of a subpoena but will do everything in our power to keep your records private. Usually, a court order will be required.
- If you are applying for your health insurance benefits, we may be required to provide information to your health plan, including some or all of your patient chart, in order for them to approve payment. By signing the "Acknowledgement of Policies and Procedures" you consent to release that information to your health plan.
- If you are party to child custody litigation at any time in the future, the court may order the release of information about your treatment.
- In some circumstances, as provided by the state law of Louisiana, information about your healthcare may be exchanged with other healthcare professionals involved in your treatment. _____ **(Initials)**

Disclosure and Confidentiality

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents, as well as business associates of the practice. The definition of a health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. If you would like information submitted to one of these companies, authorization will be required, unless it is already mandated by state or federal law.

The following routine situations necessitate the use of your information:

For Treatment - We may use information about you in order to provide you with proper medical treatment or services. Treatment is when we provide, coordinate, or manage your healthcare and other services related to your

healthcare. An example of treatment is when we consult with another healthcare provider, such as your primary care provider.

For Payment - We may use and disclose information about you so that the treatment and services you receive can be collected from an insurance company, or a third party (including a collection agency if necessary). For example, we may give your health insurance plan information about services you received at the practice, so your health insurance can reimburse the services. We may also tell your health insurance plan about a treatment you are going to receive, in order to obtain prior approval or determine if your plan will cover the treatment.

For Healthcare Operations - We may use and share information about you for administrative functions necessary to run the practice and promote quality care. We may share information with business associates who provide services necessary to run the practice, such as transcription companies or billing services. Also, we may permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care - This practice may contact you to provide appointment reminders, information about treatment alternatives, or other health-related benefits and services that may be of interest to you. Overall, it is our mission to honor the confidentiality of our patients with the utmost regard. Information disclosed will be directly relevant to such a person's involvement with your care or payment related to your care. In emergencies or other situations in which you are unable to indicate your preference, we may need to share information about you with other individuals or organizations to coordinate your care or notify your family. _____ **(Initials)**

Special Circumstances in the Release of Private Information

The following special circumstances necessitate the use of your information:

As Required by Law - We will disclose information about you when required to do so by federal, state or local law. For example, we may release information about you in response to a valid court subpoena.

Health Oversight Activities - We may disclose information to a health oversight agency for activities authorized by law. For example, these oversight activities include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

For Judicial or Administrative Proceedings - If you are involved in a court proceeding, and a request is made for information about the professional services that you have received within our practice and the records thereof, such information may be privileged under state law. We will not release information without the written authorization of you or your legal representative, or in the instance of issuance. This may also be the case in the instance of a court subpoena, which requires the provision of such information, of which you have been properly notified. In response, you have not opposed the court subpoena within the legally specified format and time frame, or in the instance of the issuance of a court order compelling us to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.

To Avert Serious Threat to Health or Safety - We may disclose your confidential mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threats of harming another individual may be reported to appropriate authorities.

Worker’s Compensation - If you file a worker's compensation claim with certain exceptions, we must make available at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Louisiana Department of Labor, to your employer, your representative, and the

Louisiana Department of Labor upon request.

Public Health Risks - We may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:

a. To prevent or control disease, injury, or disability

b. To report child abuse or neglect

c. To report adult and domestic abuse

d. To report reactions to medications or problems with products

e. To notify people of recalls of products they may be using

f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition

g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Law Enforcement - We may release information about you if asked to do so by a law enforcement official:

a. In response to a court order, subpoena, warrant, summons, or similar process

b. To identify or locate a suspect, fugitive, material witness, or missing person

c. If you are suspected to be a victim of a crime, generally with your permission

d. About a death we believe may be the result of criminal conduct

e. About criminal conduct at the hospital

f. In emergency circumstances involving a crime; the location of the crime or victims; or the identity, description, or location of the person who committed the crime.

Other uses and disclosures of information not covered by this notice or the laws that apply to our practice will be made only with your written permission. If you provide this practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that we are required to retain our records of the care that we provided to you. _____ **(Initials)**

Notice of Privacy Practices Acknowledgement

The Health Insurance Portability and Act of 1996 (HIPPA) requires that healthcare agencies/ providers provide a Notice of Privacy Practices.

Your initial acknowledgment that you have received a Notice of a privacy statement from Integrity Mental Health Services, LLC _____(initial).

Clients Rights

- The right to be treated with dignity and respect.
- The right to be informed of and participate in the selected treatment modality.
- The right to receive a copy of this consent.
- The right to withdraw this consent at any time.

Emergencies

I understand that I may reach Integrity Mental Health Svc. Provider via text at 225-308-1425 after hours. If I have a life-threatening emergency situation (I feel suicidal, homicidal, or have a medical emergency), I will call 911 and /or go to my nearest emergency room. If I have an urgent situation (medication side effects, increase in symptoms, etc.) my call will be returned as soon as possible. All routine calls will be returned the next business day.
_____(initial)

Changes to Notices

We reserve the right to revise or change provisions on this Notice. We will make the new notice provisions effective for all confidential information we maintain. Our clinic will promptly revise and distribute Notice whenever there is a change to the uses or disclosures, your rights, and our duties, or other privacy practices stated in this Notice. We will mail updates of our notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. _____ **(Initials)**

Patient Records

An electronic record is kept of services you receive in this office. You have a right to see the record and receive a copy of it upon request. You may ask that factual errors in the record be corrected. You may authorize in writing that copies of the record be released to medical providers you designate at no cost or may be picked up in person at your expense for a fee, according to charges stipulated by the state law of Louisiana. Under certain circumstances where seeing the record may put a patient or other person at risk, we may redact certain information in the record and/or require that you review the record in consultation with another healthcare provider. You may receive an accounting of non-routine uses and disclosures of your record. _____ **(Initials)**

Concerns for Safety

If as a patient, you are deemed a safety concern for self and/or others or are assessed during evaluation to have declined physically and emotionally to the point that self-care is an issue, it is our legal obligation to inform mental health deputies or officials for further action which may include detainment or acute psychiatric hospitalization. In such events as noted above, your confidentiality and your records will be released to officials and the aftercare facility. _____ **(Initials)**

Right to Terminate Treatment

In certain rare circumstances, our clinic may reserve the right to terminate your treatment at Integrity Mental Health Services LLC. We will immediately notify you if this occurs. In the event of misuse of prescriptions or in the case that your treatment is no longer seen as therapeutic, such that our options are maximized and further rapport and agreement in your care is compromised, then we may terminate our relationship. We will do our best to recommend further referrals. We also reserve the right to terminate your privileges as a patient in the event of repeat nonpayment. We will do our best to accommodate any financial difficulties through payment plans if concerns are discussed with us. We also reserve the right to terminate treatment with repeat missed appointments.
_____(initial)

Payment

As a patient, you must be aware of current established payment policies. Prior to your established visits, please thoroughly read and acknowledge our established payment guidelines as outlined below. Acceptable methods of payment include cash or money order. The fee schedule is in place for patients making payments directly to the clinic without a third-party payor source (Insurance). Fees are subject to change; however, any changes will be discussed with you. Payment for psychiatric services is due in full at the time of service unless prior arrangements have been made. You will be responsible for the full amount of payment at the time of your appointment.

Advance Directive or Living Will

An Advance Directive is a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

- The patient has a living will. _____
- I will not be executing a living will.

I understand and agree to the policies and procedures of Integrity Mental Health Services, LLC, and consent for treatment: _____ (initial)

CANCELLATION POLICY ACKNOWLEDGMENT

We understand that sometimes a patient is unable to make a scheduled appointment due to unforeseen circumstances. However, we require patients to reschedule or cancel appointments within 24 hours of a scheduled visit. **Commercial / Insurance patients** who fail to cancel or reschedule an appointment within 24 hours are subject to the following fees: (which will be charged to the card on file). **Medicaid clients will miss will have to get approval from the provider to schedule another appointment.**

Fees: (****Excluding Medicaid Patient, unless you have dual insurance***)

- No-show/ Non- Cancellation or Late Cancellation New Patient Fee: **$50**
- No-Show/ Non-Cancellation or Late Cancellation Routine Follow-up fee **$35**

Termination from Integrity Mental Health Services

- 2 consecutive No-Show
- 3 rescheduling of appointments
- Noncompliant with medication

Missing an appointment prevents us from giving you the care needed. Missed appointments are also detrimental to the providers/ staff because they prevent us from scheduling another appointment that needs care as well.

Your signature below acknowledges that you have read and understand the No Show/ Late Cancellation Policy. _____ (initial).

*****Unfortunately, we have had clients who have insurance with more than one carrier and fail to provide the information (including some Medicaid clients who may have primary insurance and Medicaid). Which has resulted in difficulty in billing/ collecting**.

***We will be requiring everyone to keep a credit card on file. **We will run the card for 10 Cent and refund to see if the card is active. fees.**

- *** NO CARD WILL BE CHARGED UNLESS A FEE IS OWED***
- Medicaid members will be discharged from services if they provide Medicaid insurance only and have commercial insurance but do not reveal.

***CREDIT CARD INFORMATION WILL BE VERIFIED PRIOR TO AN APPOINTMENT ON SCHEDULE. ***

Full Name on Credit Card_____
Credit Card Number_____
Security Code_____
Expiration Date _____ mm/yyyy
Credit Card zip Code_____

This authorization relates to all balances not covered by my insurance company for services provided by Integrity Mental Health Services. This could be amounts resulting from balances related to copayment, deductible, co-insurance, non-covered services, or denials for no coverage/ eligibility but is not limited to these scenarios.

I authorize Integrity Mental Health Services to charge my credit card above if there are any for services not covered by insurance or no-show fees. I understand that information will be saved on file for future pending transactions on my account. _____ (initial)

I certify that I am an authorized user of this card and that I will not dispute the payment with my credit card company if payment is owed to Integrity Mental Health Services.

Patient Name_____ Patient Signature_____

ACKNOWLEDGEMENT OF POLICIES AND PROCEDURES AND CONSENT FOR TREATMENT

As a healthcare provider, we are required to make you aware of Integrity Mental Health Services LLC's policies and procedures. By signing below, you consent to the agreement of your rights as a patient and understand that these rights may be limited by certain legal policies implemented to protect your safety, you also understand and agree to all the specified clinic rules and procedures and acknowledge that failure to follow such guidelines on your behalf as a patient may result in termination of your treatment.

Integrity Mental Health Services LLC's policies may be subject to change, of which you will be informed at your next clinic visit.

I, the patient or patient's legal representative, hereby grant permission for the providers at Integrity Mental Health Services to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that healthcare is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. Hereby, I consent to be treated with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable.

I understand and agree to the policies and procedures of Integrity Mental Health Services LLC and consent for treatment:

Patient Signature: _____ Date: _____

Printed Name: _____

Patient Representative:

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____Relationship to Patient: _____

Signature: _____ Date: _____