**Psychiatr****ic Services**

(719) 644-0040 Fax-(719)452-3491

**Contact@ColoPsychiatric.com**

[**www.ColoPsychiatric.com**](http://www.ColoPsychiatric.com)

***Name:*** *First: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Middle Initial: \_\_\_\_ Last: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Social Security #: \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_***

***Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: M S D W***

***Home Phone: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ Work: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Cell: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other: (\_\_\_\_\_)-\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***Messages may be left on: Home phone\_\_\_\_ Cell phone\_\_\_\_ Work phone\_\_\_\_ Email\_\_\_\_***

***Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***EMERGENCY CONTACT:*** *Name:* ***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*** *Relationship:\_\_\_\_\_\_\_\_\_*

*Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***PRIMARY INSURANCE : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*INSURED ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP/POLICY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***POLICY HOLDER’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***PATIENT’S RELATIONSHIP TO POLICY HOLDER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

***POLICY HOLDER’S DOB \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_***

***SECONDARY INSURANCE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Effective Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

*INSURED ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ GROUP/POLICY #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

I authorize Psychiatric Services to release information from my medical records as may be necessary or requested by my insurance company to

process claims and to my primary care and/or referral providers for continuity of care. I authorize payment directly to Psychiatric Services,LLC

of the benefits otherwise payable directly to me under the terms of my insurance. I understand I am financially responsible for charges not covered

as detailed in the Practice Policies. If collection action is necessary, I understand that I am responsible for payment of all expenses of collecting

my unpaid balance, including attorney fees, and that I specifically relinquish privilege of confidentiality necessary to process my account.

This signature also is my consent for treatment and access to pharmacy records.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

(Parent if minor)

**CURRENT MEDICATION LIST: (PLEASE LIST ALL YOUR CURRENT MEDS, VITAMINS, SUPPLEMENTS)**

**Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medication Allergies:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Provider:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Therapist:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Height\_\_\_\_\_\_\_\_\_\_ Weight\_\_\_\_\_\_\_\_\_\_ Cigarettes? No\_\_\_\_\_ Yes\_\_\_\_\_\_ Frequency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MEDICATION DOSE INSTRUCTIONS PURPOSE**

|  |  |  |  |
| --- | --- | --- | --- |
| ***(EXAMPLE) Lisinopril*** | ***10mg*** | ***One daily*** | ***High blood pressure*** |
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**Psychiatric Services, LLC**

Practice Policies

Welcome to our office! We are pleased that you have chosen us to provide your care and services. We would like to inform you of our policies. We accept cash, personal checks and credit cards for payment.

**No Insurance/Non-Contracted Insurance:** We are a preferred provider for all major insurance companies, however there may be some plan exceptions. Please contact your carrier for verification. We will bill your insurance for you, but all co-pays and past due amounts are due prior to the time of service.

**Medicare:** Psychiatric Services. LLC is participating provider for the Medicare program. We will submit your claim/ services to Medicare. If you have a secondary or supplemental, we will submit after payment from Medicare, however, we must have a copy of your card and the appropriate information.

**Medicaid and Medicaid HMO:** We ***do not***  participate with any Medicaid programs.

**Contracted Insurance (HMO, PPO, EPO, POS):** If you have insurance we are contracted with, we submit your insurance claims for you, if you supply us with the necessary information. This includes a copy of your card, the address to submit clams to and a telephone number to allow us to verify coverage. You are still responsible for payment of your co-payment at the time of service and any amounts not covered by your insurance, including deductible. If your coverage is denied for any reason you are responsible for payment of the entire balance due, based on our normal fee schedule.

**Workers Compensation:** We will bill your workers compensation for your work related injury. We will need the claim number, the name of your insurance, the name and phone number of your adjuster. If your carrier determines it is not work related we will then bill you directly or your health insurance if you have provided us with this information at the time of service.

**Auto Accidents:** We will bill your auto insurance if you provide us with the name of your insurance, the claim number as well as the adjusters name and phone number. If your auto benefits are exhausted we will need the name of your health insurance or you will be responsible for the charges.

**Ancillary Services:** If lab work is needed, an order will be written. It is your responsibility to determine what facilities your insurance participates with to lower your costs.

**Co-payments:** Co-payments or co-insurance is due at the time of service prior to the appointment. A minimum of $50.00 will be collected if no copayment is specified on your insurance card or we are not familiar with your behavioral health insurance.

**No Show, Missed, Cancellation and Failed Appointment Fees:** Late cancelations of follow-up evaluations with less than 48 business hours advance notice are charged $25.00, and missed or failed follow-up appointments are charged $50.00. No show, failed and late cancel fees are not billed to your insurance. Payment is due prior to rescheduling your appointment. The new patient appointment charge is $150 if cancelled, missed or failed and are not rescheduled.

**Returned Check Fees:** Checks returned for insufficient funds or closure of account will have an additional fee of $50.00 plus the amount that was due. You are responsible for any bank fees charged to you by your bank. Your account will be put on a cash pay only basis thereafter.

Psychiatric Services, LLC Practice Policies (Page 2 of 2)

**Copies of Records:** Records will be released and forwarded to a new psychiatric provider at no charge with a valid release of information. A fee of $2.00 per page will be due prior to the records being released to other providers, courts, schools. etc. with a valid release of information.

**Preparation of Letters, Medical Excuses, or Other Special Reports or Forms Completion:** Please complete the patient portion of the form prior to submitting it to Colorado Psychiatry. If the form must be completed between appointments, a fee of $5.00 per minute will be charged and due upon completion and prior to be given to you.

**Legal Advocacy:** Legal fees are not reimbursed by medical insurance companies and are due and payable prior to the appointed time with a 5 business day cancelation policy. In office legal fees: $250/hour. Out of office legal fees including door to door time plus expenses: $450/hour. If not canceled prior to 5 business days, fees will remain the full fee.

**Refill of Medications:** Every effort is made to insure adequate refills are given to last until the next scheduled appointment. If an additional refill is needed, your pharmacy submits an additional refill request or replacement prescriptions are needed there will be a $15.00 charge (not submitted to insurance).

**Assignment of Benefits and Authorization to Release Information:** I hereby assign my Medicare and/or any other insurance benefits to which I am entitled. I authorize and direct my insurance carriers(s) including private insurance, and other health /medical plan to issue payment by check(s) directly to Psychiatric Services LLC for services rendered to me or my dependents regardless of my insurance benefits, if any.

I authorize Psychiatric Services LLC to furnish and/or release any information necessary to insurance carriers concerning my illness or treatment to process my insurance claims and a photocopy of my signature can be used to process my insurance claim for the period of a lifetime. This order will remain in effect until revoked in writing.

I have requested medical services from Psychiatric Services LLC on behalf of my dependents or myself and I understand that by making this request, I become fully responsible for any and all charges incurred in the course of treatment authorized. I further understand that fees are due and payable on the date that services are rendered and agree to pay all charges incurred immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original. ***Insurance coverage is a matter between my insurance company and myself; I am ultimately responsible for the payment of my account.***

**"I agree that in the event that my account is turned over to a collection agency or attorney due to non-payment, that I will pay up to an additional 50 % of the balance as reasonable collection fees (to be added to the balance at the time the account is placed for collection)  plus any court costs and attorney's fees incurred in connection with the collection of my account."**

***I have had the opportunity to read and understand the payment policies set forth and have been given the opportunity to ask questions about these policies. I understand my responsibility for payment to Psychiatric Services, LLC.***

**Printed Name (Responsible Party over 18 years old)**

**Signature Date**

**Psychiatric Services, LLC**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES & PRACTICE POLICY**

PATIENT NAME (PLEASE PRINT) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I ACKNOWLEDGE THAT I HAVE RECEIVED OR WAS OFFERED A COPY OF THE NOTICE OF**

**THE PRIVACY PRACTICES AND PRACTICE POLICIES FOR PSYCHIATRIC SERVICES, LLC.**

SIGNATURE OF PATIENT OR GUARDIAN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

**FOR OFFICE USE ONLY**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

DOCUMENTATION OF GOOD FAITH EFFORT

(FOR USE WHEN ACKNOWLEDGMENT CANNOT BE OBTAINED FROM PATIENT)

The patient presented himself/herself to the office on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and was provided a copy of the

Notice of Privacy Practices and Practice Policy. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgment was not obtained because:

* **Patient Refused to sign**
* **Patient was unable to sign or initial due to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Patient had a medical emergency and an attempt to obtain the acknowledgment will be made**

**at the next opportunity.**

* **Other reason/describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Employee Completing Form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Your Rights and Protections Against Surprise Medical Bills**

|  |
| --- |
| **When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.** |

**What is “balance billing” (sometimes called “surprise billing”)?**

“When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn’t in your health plan’s network

**Out-of-network”** describes providers and facilities that haven’t signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called “**balance billing**.” This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

**“Surprise billing”** is an unexpected balance bill. This can happen when you can’t control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

**You are protected from balance billing for:**

**Emergency services**

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You **can’t** be balance billed for these emergency services. This includes services you may get after you’re in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you have a “CO\_DOI” on your health insurance ID card and you are receiving care and services provided at a regulated facility or agency in Colorado you can only be billed for your plan’s in-network cost-sharing amounts, which are copayments, deductibles, and/or coinsurance. You cannot be billed for anything else. This applies only to services related to and billed as an “emergency service”.

**Certain services at an in-network hospital or ambulatory surgical center**

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can’t** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can’t** balance bill you, unless you give written consent and give up your protections.

**You’re never required to give up your protections from balance billing. You also aren’t required to get care out-of-network. You can choose a provider or facility in your plan’s network.**

**If you have a “CO\_DOI” on your insurance ID card and you are receiving care and services at a regulated facility or agency in Colorado:**

**Non-emergency Services at an In-Network or Out-of-Network Facility**

Facility or agency staff must tell you if you are at an out-of-network location or if they are using out-of-network providers when known. Staff must also tell you what types of services you will be using that might be provided by an out-of-network provider.

You have the right to request that in-network providers perform all covered medical services. However, you may have to receive medical services from an out-of-network provider if an in-network provider is unavailable. If your insurer covers the service, you can only be billed for your in-network cost-sharing amount, which are copayments, deductibles, and/or coinsurance.

**Additional Protections**

1. Your insurer will pay out-of-network providers and facilities directly.
2. The provider or facility or agency must refund any amount you overpay within 60 days of being notified.

**When balance billing isn’t allowed, you also have the following protections:**

1. You are only responsible for paying your share of the cost (like the copayment's, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
2. Your health plan generally must:
   1. Cover emergency services without requiring you to get approval for services in advance (prior authorization).
   2. Cover emergency services by out-of-network providers.
   3. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
   4. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed, you may contact 800.985.3059 regarding federal regulations, or the Colorado Division of Insurance at 303.894.7499 or 1.800.930.3745 for Colorado regulations, or the facility’s or agency’s billing department. Visit cms.gov/nosurprises/consumers for more information about your rights under federal law. My signature acknowledges receiving this notice and does not waive my rights under the law.

Printed Name Signature Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_