
Phone: (913) 548-3734
Fax: (913) 624-9596
www.beewellpsychiatry.com
contact@beewellpsychiatry.com

## Patient Disclosures and Consents

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize direct payment of my insurance benefits to Bee Well Psychiatric Associates, LLC individually for services rendered to my dependents or me by the PMHNP or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that Bee Well Psychiatric Associates, LLC is unable to collect from my insurance carrier for whatever reason.

MEDICARE/MEDICAID/CHAMPUS INSURANCE BENEFITS: I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Bee Well Psychiatric Associates, LLC on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION: I certify that I have received and read a copy of the Bee Well Psychiatric Associates, LLC Patient Information Privacy Policy. I hereby authorize Bee Well Psychiatric Associates, LLC or the PMHNP individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR E-MAIL: I certify that I understand the privacy risks of the mail, phone calls, and e-mail. I hereby authorize a Bee Well Psychiatric Associates, LLC representative or my provider to mail, call, or e-mail me with communications regarding my healthcare, including but not limited to such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Bee Well Psychiatric Associates, LLC to that effect in writing.

LAB/DIAGNOSTIC SERVICES: I understand that I may receive a separate bill if my medical care includes lab, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT: I hereby consent to evaluation, testing, and treatment as directed by my Bee Well Psychiatric Associates, LLC providers or his or her designee.

*Patient Signature (or Parent/Guardian if patient is under 18):* *Date:*

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## Financial and Missed Appointment Policy

*Thank you for choosing our office as your mental health care provider. We are committed to providing you with the highest quality mental health care. Please understand that payment is considered part of your treatment. The following is a statement of our financial and missed appointment policy, which we require that you read, agree to, and sign prior to any treatment.*

**Payment is due at the time service:** Our office is unable to accept checks at this time. We do, however, accept cash, MasterCard, Visa, and Discover.

**Credit Card on File Authorization and Agreement:** It is our goal to be as transparent as possible with all billing-related matters. Our policy regarding patient balance resolution is as follows:

1. All co-pays, as dictated by your insurance policy, are due prior to your designated appointment time. Un-insured and Private Pay patients are responsible to pay their entire Private Pay cost prior to their appointment time. This is required prior to receiving any of our services.
    a. **By signing this agreement, you understand and consent to Bee Well Psychiatric Associates, LLC utilizing your credit card on file to automatically charge necessary co-pay and private pay amounts within 7 days prior to your appointment time.**
2. After each appointment with Bee Well Psychiatric Associates, LLC, your provider will submit a claim to your insurance (if applicable). You may have a patient balance due after the insurance processes your claim for the date of service.
    a. This amount is designated by your insurance policy, not by our organization. Any discrepancies will need to be communicated between you and your insurance provider.
3. All balances due will be met with a Square invoice sent to your email address on file. This invoice will be set as due "upon receipt."
4. If a balance remains unpaid, an automatic reminder will be sent to you on Day 29 post-invoice. This reminder will notify you that we will charge the total balance to your credit card on file in the next 24 hours.
5. On Day 30, the total balance will be charged to your card unless you have contacted the office and consented to a payment plan in writing with our office. The receipt will automatically be emailed to you.
6. You may contact our office at any time to request additional receipts.
7. It is your responsibility to notify us of changes to your credit card on file. **Errors with the use of this card on file may result in your appointment being canceled until card details are updated.**
8. You may request to opt-out or cancel this authorization by email ONLY. If you have any pending or current balance, then failure to pay in full will result in the cancellation of follow-up appointments and/or request for medication refills.

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*I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify BeeWell Psychiatric Associates, LLC via the Patient Portal of any changes in my account information or via email for termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that BeeWell Psychiatric Associates, LLC may at its discretion attempt to process the charge again within 15 days, from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.*

**By signing below, I authorize BeeWell Psychiatric Associates, LLC to charge my credit card above for agreed-upon purchases. I understand that my information will be saved to file for future transactions on my account.**

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Patient Signature (or Parent/Guardian if patient is under 18) Date

**By signing below, I understand that any outstanding balances on my account, including incorrect or denied credit card on file details, will result in a freeze on my account in which no scheduling of follow-up appointments or refills on medications may occur.**

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Patient Signature (or Parent/Guardian if patient is under 18) Date

Insurance Policy: All charges incurred related to your services are your patient responsibility, regardless of your insurance coverage. We must emphasize that as your mental health care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company, our office is not a party to that contract. Our practice is committed to providing the best treatment for our patient. You are responsible for payment regardless of your insurance policy's determination of usual and customary rates.

- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- **By signing below, I authorize the release of any information concerning my (or my child's) health care advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.**

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- We ask that you pay the deductible, co-payment, co-insurance amounts not covered by your insurance policy via cash, MasterCard, Visa, and Discover card at the time we provide the service to you.

Insurance payments are ordinarily received within 30-60 days from the time of filing a claim. If your insurance company has not made payment within 90 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claims.

**I have read and agree to the above terms and conditions. I authorize my insurance company to pay directly to my mental health care provider's office.**

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Patient Signature (or Parent/Guardian if patient is under 18) Date

**Missed Appointments/Cancellations:** It is our goal to provide treatment in a timely manner. In order to provide the best services to our patients, we require a minimum 24-hour notice for all cancellations or rescheduling requests. A $25 No-Show Fee will be applied to your account for any last-minute cancellations or rescheduling requests as well as missed appointments. We understand that unforeseen circumstances may arise, and we encourage an open line of communication between all patients and our office.

**Additional Fees:**

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| Letter Request from Provider (*ex. Return to work letter)* | $25/page |
| Medical Records Requests (up to 20 pages) | $10 *(+ $1/page for each additional page)*<br>***Additional mailing/shipping costs may apply* |
| All Paperwork/Form Requests | $75/hour for provider's time<br>*(+ additional $15/page for forms greater than 5 pages)* |

*Note: We require 10-15 business days to process any forms/paperwork, letter writing services, medical records requests, etc. This timeframe begins after the service fee has been received.*

**By signing below, I have read and agree to the terms listed above.**

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Patient Signature (or Parent/Guardian if patient is under 18) Date

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**Notice of Privacy Practices (HIPAA Compliance)**

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

The law requires us to keep your protected health information ("PHI") private in accordance with this Notice of Privacy Practice ("Notice") as long as this Notice remains in effect. We are also required to provide you with a paper copy of this Notice, which contains our Privacy practices, our legal duties, and your rights concerning your PHI. This notice is also available on our website, www.beewellpsychiatry.com. From time to time, we may revise our privacy practices and our Notice at any time, as permitted or required by applicable law. Such revisions to our privacy practices and our Notice may be retroactive. Our Notice will be updated and made available to our patients prior to any significant revisions of our privacy practices and policies.

**WHO WILL FOLLOW THIS NOTICE**

This Notice describes the privacy practices of Bee Well Psychiatric Associates, LLC (the "Practice") and that of our business associates, who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with Bee Well Psychiatric Associates, LLC, to protect the privacy and to ensure the security of your PHI.

**Our Privacy Practices**

*Use and Disclosure*. We may use or disclose your PHI for treatment, payment, or health care operations. For your convenience, we have provided the following examples of such potential uses or disclosures:

*Treatment*. We may use or disclose Your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to any physician or other health care providers; such as PCP, Specialist, Laboratories or Pharmacy involved with the medical services provided to you.

*Payment*. Your PHI may be used or disclosed in order for us to collect payment from you, a health plan, or a third party for the medical services provided to you by us. For example, we may need to give your health plan information about your treatment in order for your health plan to agree to pay for that treatment, or undertake utilization review activities for determination of eligibility or insurance coverage benefits.

*Health Care Operations*. Your PHI may be used or disclosed as part of our internal health care operations. For example, we may also disclose information to physicians, nurses, medical

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technicians, medical students, and other authorized personnel for educational and learning purposes.

*Required by law*. We may use or disclose your medical information when we are required to do so by law. For example, your PHI may be released when required by privacy laws, workers' compensation or similar laws, public health laws, court or administrative orders, subpoenas, certain discovery requests, or other laws, regulations or legal processes. Under certain circumstances, we may make limited disclosures of PHI directly to law enforcement officials or correctional institutions regarding an inmate, lawful detainee, suspect, fugitive, material witness, missing persons, or a victim or suspected victim of abuse, neglect, domestic violence or other crimes. We may disclose your PHI to the extent reasonably necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose your PHI when necessary to assist law enforcement officials to capture a third party who has admitted to a crime against you or who has escaped from lawful custody.

*Deceased persons*. After your death, we may disclose your PHI to a coroner, medical examiner, funeral director, or organ procurement organization in limited circumstances. We may make relevant disclosures to the deceased's family and others who were involved in the care or payment for care of the deceased prior to death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the practice.

*Inmates*. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety of the health and safety of others; (3) for the safety and security of the correctional institution.

*Research*. Your PHI may also be used or disclosed for research purposes only in those limited circumstances not requiring your written authorization, such as those, which have been approved by an institutional review board that has established procedures for ensuring the privacy of your PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. However, we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.

*Military and National Security.* If you are a member of the armed forces, we may use or disclose your PHI as required by military command authorities. When required by law, we may disclose your PHI for intelligence, counterintelligence, and other national security activities.

*Out-of-Pocket Payments*. If you paid out-of-pocket (in other words, requested that we do not bill your health plan or did not have insurance coverage) in full for a specific treatment or service, you have the right to request that your PHI with the respect to that specific treatment or service not be disclosed to a health plan for the purposes of payment or healthcare operations.

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**Privacy Policy for SMS Communication**

*Text Communication with Patients:* Bee Well Psychiatric Associates, LLC is committed to protecting your privacy. We understand the importance of keeping your personal information secure and confidential. This section outlines our policies regarding SMS communication with our patients.

*Collection and Use of Phone Numbers:* When you opt-in to receive SMS communications from Bee Well Psychiatric Associates, LLC, we collect your phone number solely for the purpose of sending you text messages related to our services. This may include appointment reminders, updates, and other important information relevant to your care.

*Privacy and Security:* We are committed to ensuring that your phone number and any other personal information you provide to us are protected. We implement appropriate technical and organizational measures to safeguard your data against unauthorized access, disclosure, or misuse.

*No Sharing or Selling of Information:* Bee Well Psychiatric Associates, LLC does not share, sell, rent, or trade your phone number or any information related to your SMS opt-in with third parties for any purpose. Your information is used exclusively for the purposes outlined in this policy.

*Opting Out:* You have the right to opt-out of receiving SMS communications from us at any time. To stop receiving text messages, simply reply STOP to any of our SMS messages. Your request will be processed promptly, and you will no longer receive SMS communications from Bee Well Psychiatric Associates, LLC.

*By opting in to receive SMS communications, you acknowledge that you have read and understood this privacy policy section and agree to its terms. If you have any questions or concerns about our SMS communication practices, please contact our office directly.*

**Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt Out**

*Individuals Involved In Your Care or Payment For Your Care*. With your permission, or in some emergencies, we may disclose to your family members, friends, or any other person you identify, your PHI that directly relates to that person's involvement in your healthcare or payment related to your healthcare. A disclosure of your PHI may also be made if you are unable to agree or object to such disclosure and we determine it is reasonably necessary or in your best interests for such purposes as allowing a person acting on your behalf to receive filled prescriptions, medical supplies, X rays, etc.

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*Disasters*. We may use or disclose your PHI to a public or private entity authorized by law to assist in disaster relief efforts to coordinate your care, notify or identify family, friends or other persons identified by you as being responsible for your care. If we determine in our reasonable professional judgment that you are capable of doing so, you will be given the opportunity to consent to or to prohibit or restrict the consent to or to prohibit or restrict the extent of recipients of such disclosure. If we determine that you are unable to provide such consent, we will limit the PHI disclosed to the minimum necessary.

**Disclosures Requiring Written Authorization**

1. Uses and disclosures of Psychotherapy Notes
2. Uses and disclosures of your PHI for marketing purposes
3. Disclosures that constitute a sale of your PHI
4. Other uses and disclosures not described in this notice

These uses and disclosures of your PHI will only be made with your written authorization, unless otherwise required by law. We may request such an authorization to use or disclose your PHI for any purpose, but you are not required to give us such authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized use and disclosure.

**Your Rights Regarding Your Protected Health Information**

*Access and Copies*. In most cases, you have the right to review or to purchase copies of your PHI by requesting access or copies in writing. We may charge you a reasonable fee for the cost of copying, mailing, or other supplies associated with your request.

*Electronic Copy of your Record.* If your PHI is maintained in an electronic format (known as electronic medical record or electronic health record) you have the right to request an electronic copy of your PHI be given to you or transmitted to another individual or entity. We will make every effort to provide access to your PHI in the form or format you request, if it is readily producible in such form or format. If the PHI is not readily producible in the form or format you request your PHI will be provided in either our standard electronic format or if you do not want this form or format, a readable hard copy form. We may charge you a reasonable, cost-based fee for the labor associated with transmitting the electronic data.

*Disclosure accounting*. You have the right to receive an accounting of the instances, if any, in which your PHI was disclosed for purposes other than treatment, payment, or health care operations. This excludes disclosures we may have made to you or to family members or friends involved in your care, or for notification purposes. To request this list or accounting of

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disclosures, you must submit your request in writing. Your request must state a time period which may not be longer than six years and may not include dates before April 13, 2003. For each 12-month period, you have the right to receive one free copy of an accounting certain details surrounding such disclosures that occurred after April 13, 2003. If you request a disclosure accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for each additional request. The right to receive this information is subject to certain exceptions, restrictions and limitations.

*Additional Restrictions*. You have the right to request that we place additional restrictions on our use or disclosure of your PHI, but we are not required to honor such a request. To request restrictions, you must make your request in writing to the Privacy Officer to the address provided at the end of this notice. In the request, you must specify what information you want limited or restricted, whether you want to limit our use or disclosure or both, and to whom you want the limits to apply, for example, disclosures to your spouse.

*Alternate Communications*. You have the right to request that we communicate with you about your PHI by alternative means or alternative locations. We will accommodate to any reasonable request if it specifies in writing the alternative means or location, and provides a satisfactory explanation of how future payments will be handled.

*Amendments*. You have the right to request that we amend your PHI. Any such request must be in writing to the Privacy Officer at the address provided at the end of this notice and contain a detailed explanation for the requested amendment. Under certain circumstances, we may deny your request but will provide you a written explanation of the denial. You have the right to send us a statement of disagreement to which we may prepare a rebuttal, a copy of which will be provided to you at no cost. Please contact our Privacy Officer with any further questions about amending your medical records.

*Notice of a Breach*. You have the right to be notified upon a breach of any of your unsecured PHI.

**Complaints**

The Privacy Officer is:

If you believe we have violated your privacy rights, you may complain to us or the Secretary of the U.S. Department of Health and Human Services. You may file a complaint with us by notifying our Privacy Officer at the address listed above.

We support your rights to protect the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

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To file a complaint with the Secretary, mail to: Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave, S.W., Washington, D.C, 20201. Call (202) 619-0257, or toll free at (877) 696-6775 or go to the website for the Office for Civil Rights, www.hhs.gov/ocr/hipaa/, for more information.

*You have the right to refuse to sign this document*

**By signing below, I have reviewed this office's Notice of Privacy Practices.**

Patient Signature (or Parent/Guardian if patient is under 18) Date