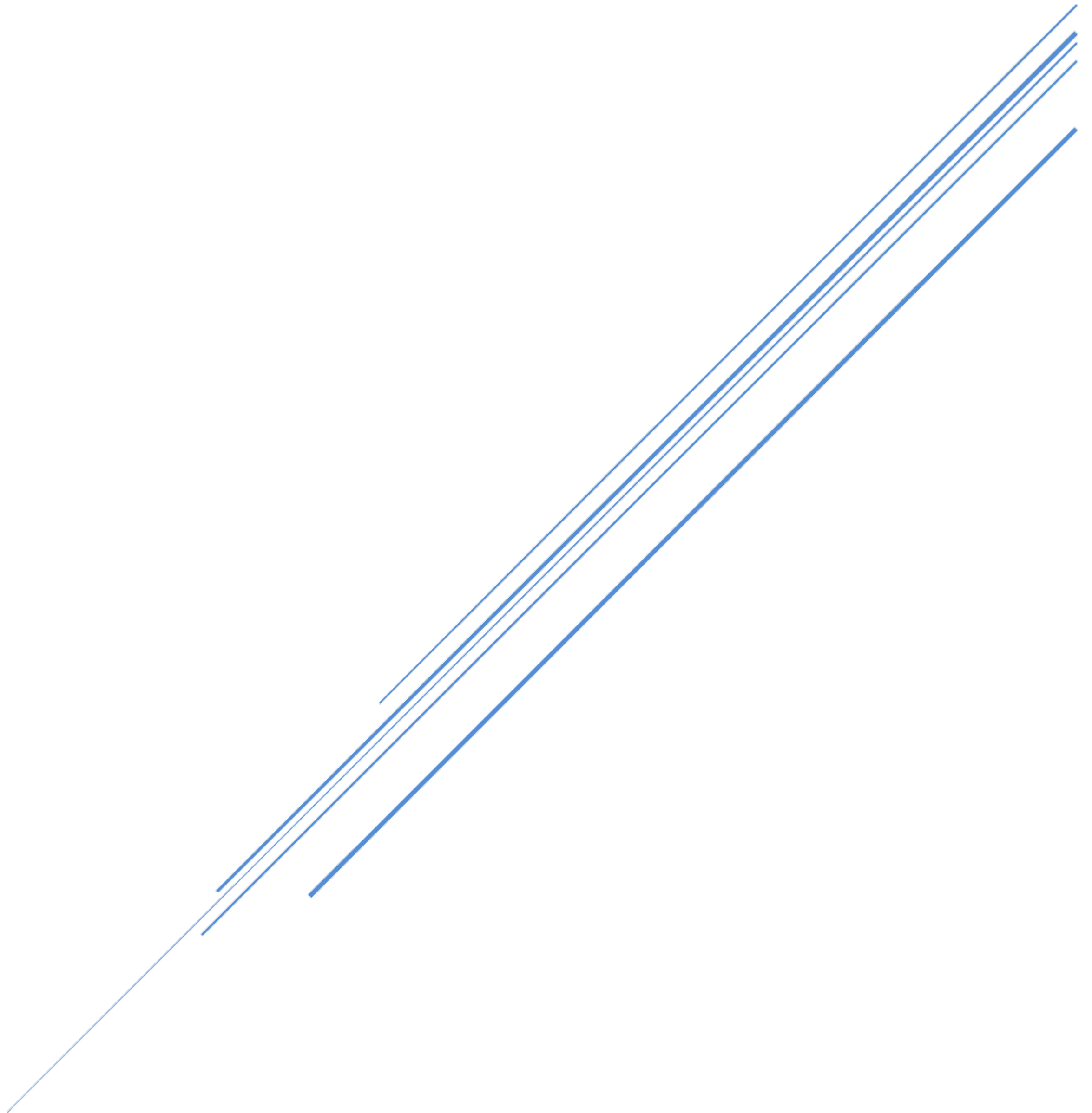
NEOGEN PSYCHIATRY

New Patient Packet



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Neogen Psychiatry

Patient HIPAA Acknowledgment and Consent Form

Patient Name (Printed):__________________________Date of Birth: ________________________

<u>Notice of Privacy Practice/clinics</u>.

________ (Patient/Representative initials) I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

<u>Disclosures to Friends and/or Family Members</u>

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?"
I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

<u>Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:</u>

We want to stay connected with our patients. Patients in our practice/clinic may be contacted via email, calls to your cellular telephone (including prerecorded/artificial voice messages and/or calls from an automatic dialing device), and/or text messaging to confirm an appointment, to obtain feedback on your experience with our healthcare team, and to be provided general health reminders/information. If at any time, you provide an email, cellular telephone number, address or text number below, you understand that you may get these communications from the Practice/clinic. You may opt out of these communications at any time (see next page).The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

I authorize to receive text messages and/or cellular telephone calls for appointment reminders, feedback, and general health reminders/information and **the cell phone number is____________________________**.
I authorize to receive email messages for appointment reminders and general health reminders/feedback/information and **the email that i**s_________________________________.

-OR-

I **decline_______**(Patient/ Representative Initials) to receive communication via text.
I **decline_______**(Patient/ Representative Initials) to receive communication via cellular telephone call.
I **decline_______**(Patient/ Representative Initials) to receive communication via email.

Note: *This clinic uses an Electronic Health Record that will update <u>all your demographics and consents</u> to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.*

<u>Release of Information.</u>

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other **Neogen Psychiatry** providers may be made available to subsequent providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.

  This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric

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reports, drug and alcohol treatment and discharge summary.

- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Only If you have previously consented to receive communication via text/cellular telephone call/email and wish to remove the consent/Opt Out/Revocation of communications via email and/or text or cellular telephone call. In other words, I do not want my email address or cell number to be used any longer for the above mentioned communications.

*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **text**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **cellular telephone call**.*
*__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via **email**.*

Patient Name: ____

Patient/Patient Representative Signature: ____
*Date:*______________________________ *Time:* ____________________

No Show Policy:

We, at Neogen Psychiatry, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 48-hour notice). You can cancel appointments by calling the following number: (817) 442-3112.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder call to you is made/attempted one (1) business day prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time. Neogen Psychiatry values each patient's time and does not overbook appointments. In order to ensure that appointments occur on time, if you are more than 10 minutes late to your appointment you may be asked to reschedule. PLEASE REVIEW THE FOLLOWING POLICY:

Please cancel your appointment with at least a 48 hours' notice as previously mentioned.

If less than a 48-hour cancellation is given this will be documented as a "No-Show" appointment.

If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

After the first "No-Show/Missed" appointment, you will receive a phone call or letter to inform you that you have had one "no-show." Neogen Psychiatry will assist you to reschedule this appointment if needed. A $100 fee will be assessed prior to rescheduling.

Following a second "No-Show/Missed" appointment within a one-year time period, you will receive a warning letter from our office and will be assessed a $150.00 no show fee that must be paid prior to rescheduling.

If you have 3 "No-Show/Missed" appointments within a one-year time, you will be dismissed from the practice and will receive a letter of dismissal from the office.

I have read and understand the Neogen Psychiatry No Show/Missed Appointment Policy and understand my responsibility to plan appointments accordingly and to notify Neogen Psychiatry appropriately if I have difficulty keeping

my scheduled appointments.

Financial Agreement:

I acknowledge, that as a courtesy, NEOGEN PSYCHIATRY may bill my insurance company for services provided to me. I agree to pay for services that are not covered, or covered charges not paid in full including, but not limited to any co-payment, co-insurance and/or deductible, or charges not covered by insurance. I understand there is a fee for returned checks. Third Party Collection. I acknowledge NEOGEN PSYCHIATRY may use the services of a third-party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing. Assignment of Benefits. I hereby assign to NEOGEN PSYCHIATRY any insurance or other third-party benefits available for health care services provided to me.

I understand NEOGEN PSYCHIATRY has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NEOGEN PSYCHIATRY, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

I agree that, in order for NEOGEN PSYCHIATRY, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that NEOGEN PSYCHIATRY or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or NEOGEN PSYCHIATRY or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using prerecorded/ artificial voice messages and/or use of an automatic dialing device, as applicable.

Credit Card Authorization Policy:
At Neogen Psychiatry, we require 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. We keep your credit card on file for the following instances:

Your credit card on file will be charged for any outstanding balance owed after two billing cycles (60 days).
You arrive for an appointment and there are late cancellation and/or no-show fees owing. These will be charged on the day of that appointment to the card you provide or card on file.
Proof of insurance is required at each visit. If you do not provide insurance information by the following day after an appointment, the cost of the visit will be charged to the credit card on file. Your credit card information is kept confidential and HIPAA secure. Payments to your card are processed only after the claim has been filed and processed by your insurer, the insurance portion of the claim has paid and posted to the account, and 60 days have passed since initial bill. You can go to the patient portal and add a credit card to have on file yourself or we are happy to do it for you.

I, the undersigned, authorize and request Neogen Psychiatry to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility or that were non covered services. This authorization relates to all payments not covered by my insurance company for services provided to me by Neogen Psychiatry. This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Neogen Psychiatry in writing and the account must be in good standing.

______________________________ ______________________________
Signature Date

Patient/Provider Controlled Substance & Non-Controlled Substance Medication Agreement:
The purpose of this agreement is to be certain that long-term controlled substances are prescribed in the safest, most effective manner in compliance with current law. Utilization of controlled substances over a long period of time may be medically useful, but may carry the risk of dependency, addiction, and loss of effectiveness. You must understand and agree to the following terms in order for us to enter with into a prescribing relationship.

- I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition.
- I understand that violating the terms of this agreement could result in discharge from the practice.
- The goal of treatment will be established with my provider and will focus on improving function, not total symptom elimination.

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- I will not obtain controlled substances from any other provider, emergency room, or urgent care facility without notifying my prescribing provider.
- I will not share, sell, or let others have access to my controlled medications.
- I will not alter a prescription, use deception to obtain a prescription, or provide prescription medicine to anyone else.
- I understand that any such activity not only violates this agreement but is also a felony offense.
- My provider will decide how often I need to be seen for office evaluation and assessment.
- My treatment will be continued only if I return to the office for these visits.
- I must schedule these visits so that I do not run out of medications.
- I will not ask for early prescriptions for renewals.

The assessment interval shall not exceed 3 months in any case. I understand that if I use my medication at a greater rate than it is prescribed for that I will run out of my medication for a period of time and that I may experience withdrawal or other dangerous effects. If my prescription is lost or stolen, I understand that I should file a police report.

- I understand that controlled substances are used as a component of a total treatment plan to control symptoms.
- I agree to participate in any and all aspects of this treatment plan that my provider feels would be in my best interest.
- I will not adjust any dosage of medication unless specifically directed by my provider. My provider will evaluate the effectiveness of my treatment plan on an ongoing basis.
- I agree to communicate fully the effect of my prescription on my symptoms. If controlled medication is not effective, I agree that discontinuing them under my provider's direction is an appropriate treatment option. I agree to notify my provider of all other medications and substances I am taking. Sedatives, alcohol, and street drugs should not be taken with controlled prescriptions. Monitoring of blood or urine of patients taking controlled substances will be a part of my care, I agree to provide samples when asked.
- I understand that my provider may wish to dedicate an appointment solely for this purpose.
- I agree to provide photo identification and comply with any other office policies for retrieving printed prescriptions.
- I understand that controlled medications may be harmful during pregnancy and agree to notify my provider if I become pregnant.

I have read and understand this agreement and have had the opportunity to have all questions answered to my satisfaction. I agree to the use of controlled substances for my condition under the terms of this agreement. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will be treating me based on the terms of this agreement. I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition. I understand that violating the terms of this agreement could result in discharge from the practice.

______________________________________ ______________________________

Signature Date

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Telehealth Consent:

Telehealth involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care. Telehealth services offered by Neogen Psychiatry may also include chart review, remote prescribing, prescription refills, appointment scheduling, health information sharing, and non-clinical services, such as patient education.

The information you provide may be used for diagnosis, therapy, follow-up and/or patient education, and may include any combination of the following: (1) health records and test results; (2) images; (3) live two-way audio and video; (4) and interactive audio. The electronic communication systems we use will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

CONSENT FOR TELEHEALTH CONSULTATION: I understand that my health care provider wishes me to engage in a telehealth consultation. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will notbe in the same room as my provider. I understand that a telehealth consultation 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 my health care provider or I can discontinue the telehealth consult/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 questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

Consent to use the telehealth by Valant EHR (Zoom) is the technology service we will use to conduct telehealth videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge: Telehealth by Valant EHR is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911. Though my provider and I may be in direct, virtual contact through the Telehealth Service, neither Simple Practice nor the Telehealth Service provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services. The Telehealth by Valant EHR Service facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care. I do not assume that my provider has access to any or all of the technical information in the Telehealth by Valant EHR Service – or that such information is current, accurate or up to date. I will not rely on my health care provider to have any of this information in the Telehealth by Simple Practice Service. To maintain confidentiality, I will not share my telehealth appointment link with anyone unauthorized to attend the appointment. That I have read or had this form read and/or had this form explained to me. That I fully understand its contents including the risks and benefits of the procedure(s).

That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction. *Options understand by checking the box associated with "Informed Consent", you acknowledge that you understand and agree with the following:

1. I hereby consent to receiving Neogen Psychiatry services via telehealth technologies. I understand that Neogen Psychiatry and its providers offer telehealth-based psychiatric and mental health services. I also understand it is up to the Neogen Psychiatry provider to determine whether or not my specific clinical needs are appropriate for a telehealth encounter.
2. I understand that federal and state law requires health care providers to protect the privacy and the security of health information.
3. I understand that Neogen Psychiatry will take steps to make sure that my health information is not seen by anyone who should not see it.
4. I understand there is a risk of technical failures during the telehealth encounter beyond the control of Neogen Psychiatry I agree to hold harmless Neogen Psychiatry for delays in evaluation or for information lost due to such technical failures.
5. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I understand that I may suspend or terminate use of the telehealth services at any time for any reason or for no reason.
6. I understand that if I am experiencing a medical emergency, that I will be directed to dial 9-1-1 immediately and that the Neogen Psychiatry providers are not able to connect me directly to any local emergency services.
7. I understand that alternatives to telehealth consultation, such as in-person services are available to me, and in choosing to participate in a telehealth consultation, I understand that some parts of the services involving tests may be conducted by individuals at my location, or at a testing facility, at the direction of the Neogen

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Psychiatry provider (e.g., drug testing, genetic testing, vital signs).

8. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
9. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes.
10. I understand that I will not be prescribed any narcotics for pain, nor is there any guarantee that I will be given a prescription at all.
11. I understand that if I participate in a consultation, that I have the right to request a copy of my medical records which will be provided to me at reasonable cost of preparation, shipping and delivery.

Patient Consent I have read this document carefully and understand the risks and benefits of the telehealth consultation and have had my questions regarding the procedure explained and I hereby give my informed consent to participate in a telehealth consultation under the terms described herein.

_________________________________ _____________________________

Signature Date

Consent for Treat:

Patient Name: ____ Date of Birth: _______________

For Patients Under 18 years of age:

I certify that I am the: Father Mother Legal Guardian

of the above-named child and I hereby give my authorization and consent for the above-named child to receive Psychiatric Outpatient Diagnostic and Treatment Services. This includes use of “Off Label” Medications.

Parent/Legal Guardian: ______________________________ Date: _________________

For Patients Over 18 years of age:

I certify that I am the patient named above and I hereby give my authorization and consent to receive Psychiatric Outpatient Diagnostic and Treatment Services. This includes use of “Off Label” medications.

Signature: _____________________________ Date: __________________

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