Patient Information

Date: ________________ Dr. Julia Irwin, M.D./Donna Bowers, P.A.

Full Name ____ Sex __________

Address ____________________ City ______________ State ________ Zip ____________

Home(   ) ________________ Work(   ) ________________ Cell(   ) ________________

Date of Birth ____________________ Social Security # ____________________

Marital Status: ________ Race: ________ Language Spoken in Home: ________________

Spouses Name ____________________ ***Emergency Contact & Number*** ____________________

♦♦

Person Responsible For Bill ________________________ Relationship to Patient: ____________

Address ____________________ City ______________ State ________ Zip ____________

Home(   ) ________________ Work(   ) ________________ Cell(   ) ________________

Date of Birth ____________________ Social Security # ____________________

♦♦

PRIMARY INSURANCE INFORMATION

Policy Holder's Name ____

Primary Insurance Company ________________________ Policy # ____________________

MUST HAVE

Group # ________________ Date of Birth ________________ Social Security # ________________

♦♦

SECONDARY INSURANCE INFORMATION

Policy Holder's Name ____

Secondary Insurance Company ________________________ Policy # ____________________

MUST HAVE

Group # ________________ Date of Birth ________________ Social Security # ________________

♦♦

Please provide the receptionist with your insurance cards so a copy can be made and kept for billing. Thank You

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the undersigned Psychiatrist/Psychotherapist/Psychologist to release any information acquired in the course of my evaluation of treatment to any pertinent Insurance Company. I shall be personally liable for any unpaid balance.

Signature ________________________________ Date ________________

AUTHORIZATION TO PAY BENEFITS: I hereby authorize payment directly to the undersigned Psychiatrist/Psychotherapist/Psychologist of any or all benefits due under the terms of this Insurance Policy to services required.

Signature ________________________________ Date ________________

Pharmacy Name & Phone Number: ________________________________

Outside Pharmacy Release: YES ________ NO ________

May we leave messages on your answering machine? YES ________ NO ____

Email Address For Patient Portal Access ________________________________

Irwin Professional Building
820 Wall Street
Norman, OK 73069
Phone (405)928-2044 Fax (405)928-2046

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or conditions and related health care services.

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, or your child, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment:
We will use and disclose you/your child's protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment:
Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations:
We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Only With Your Consent, Authorization or Opportunity to Object unless required by Law.

MENTAL HEALTH DISCLOSURE FORM

Treatment Philosophy-Explanation of Brief Therapy for Insured Clients

Brief therapy is goal-directed, problem-focused treatment. This means that a treatment goal or several goals are established after a thorough assessment. A treatment is then planned with the goal(s) in mind and progress is made toward accomplishment of that goal in a time efficient manner. You will take an active role in setting and achieving your treatment goals. Your commitment to a treatment plan is necessary for you to experience the most successful outcome. If you ever have any questions about the nature of the treatment or your care, please do not hesitate to ask. **Initial here:** _____

Limits of Confidentiality Statement

All information between the practitioner and patient is held strictly confidential. There are legal exceptions to this:

1. The patient authorizes a release of information with a signature.
2. The patient's mental condition becomes an issue in a lawsuit.
3. The patient presents as a physical danger to self (Johnson v Co. of Los Angels, 1983).
4. The patient presents as a danger to others (Tara Soff v Regents of Univ. of California, 1967).
5. Child or Elder abuse and/or neglect is suspected (Welfare & Institution and/or Penal Codes).

In the latter two cases, the practitioner is required by law to inform potential victims and legal authorities so that protective measures can be taken.

All written and spoken material from any and all sessions is confidential unless written permission is given to release all or part of the information to specified person, persons, or not to be discussed outside of the counseling sessions. **Initial here:** _____

Release Information

I authorize the release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. **Initial here:** _____

Emergency Access

A covering practitioner or I am available after hours to handle **emergencies.** By calling the main office number after hours, you will be instructed how to contact the on-call practitioner. You may be charged for a telephone consultation for more than 5 minutes.
Initial here: _____

I have been given the New Patient Brochure with all the emergency contact numbers, office policies and procedures.
Initial here: _____

Financial Terms: Insurance and Co-payments

You are responsible for obtaining prior authorization for treatment from your insurance carrier. We will bill your insurance; however, you are responsible for co-payment amounts and deductibles as set by your benefit plan. Missed appointments are not covered by your insurance and the charges associated with them are your responsibility.
Co-payment amounts are set by your benefit plan. These payments are due and payable at each appointment.

This practitioner is responsible for informing you of cost when you are beyond or outside your benefits. For special modalities of treatment not covered by your benefit plan, a written agreement needs to be signed between you and this office/practitioner. This agreement should outline your understanding that it is not a covered benefit, should cover fees that exceed the benefit plan's fee of services discount rates.

At any time during treatment should I become ineligible for insurance coverage, I will notify the office/practitioner, and I understand I will be responsible for 100% of the bill. **Initial here:** _____

I understand and acknowledge I am responsible for any balances not otherwise paid by insurance. I also understand any outstanding balances may be sent to a 3rd party at the discretion of the provider. Additionally, I understand in this instance, **I am responsible for any legal and/or collection fees above and beyond the outstanding balance at the contracted rate between the 3rd party and the provider.** Continued failure to provide payment may result in a negative credit report rating and/or legal action executed, where applicable, according to the laws in this state. **Initial here:** _____

Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hour notice, you may be billed according to the scheduled fee and instructions of your benefit plan. Repeated "no-show" appointments could result in referring you back to the insurance company for reassignment to another practitioner. Your insurance company cannot be billed for fees associated with missed or cancelled appointments. **Our missed appointment fee is $50.00. Initial here:** _____

Appeals and Grievance for Insured Clients

I acknowledge my right to request reconsideration (an Appeal) in the case that outpatient care is not certified. I understand that I can request an appeal directly through my Health Plan and that I risk nothing in exercising this right.
I also understand that I may submit a Grievance to my Practitioner at any time to register a complaint about my care or I may send the complaint directly to my Health Plan. My Practitioner has access to information and forms to facilitate this. **Initial here:** _____

FMLA & Disability Paperwork

I understand that FMLA & Disability are forms of paperwork that are asking for leave due to a serious health condition. I also understand that for my physician to be able to provide this kind of information, I will have needed to be seen by her/him for a **minimum of 1 year. Initial here:** _____

(California Only)

I understand that the California Department of Corporations (DOC) is responsible for regulating health care services. The California DOC has a toll-free telephone number (800-400-0815) to receive complaints regarding health care plans. If I have a grievance, I can contact my insurer and use the appeal and grievance process. If I need the DOC'S help with a complaint involving an emergency appeal or with an appeal that has not been satisfactorily resolved by the plan. I can call the DOC'S toll-free telephone number.
Initial here: _____

Consent to Treat

I authorize and request my practitioner to carry out psychological and/or psychiatric exams, treatment and/or diagnostic procedures with now, or during the course of my treatment become, advisable. I understand the purpose of these procedures with be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioners and me.
Initial here: _____

_____
Patient/Guardian Signature

_____
Practitioner/Witness Signature as Needed

General Consent for Child or Dependent Treatment

I am the legal guardian or legal representative of the patient and on the patient's, behalf legally authorize the practitioner/group to deliver mental health care service to the patient. I also understand that all policies described in this statement apply to the patient I represent.

_____ _____
Patient Name **Patient Social Security #**

_____ _____
Signature of Legal Guardian/Legal Rep **Date**

_____ _____ _____
Relationship to Patient **Benefit Plan Subscriber Name** **Mental Health Benefit Plan**

Patient Name: _____ Date:_____

Advanced Healthcare Directive Questionnaire

Advance Directive: 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.

Do you have advanced directives? ***Yes / No***

If yes, please check the directive that applies.

☐DNADD-Does not have advanced directive

☐DNI-Do not intubate

☐DNR-Do not resuscitate

☐HCP-Healthcare proxy present

☐HPOW-Durable power of attorney for healthcare

☐LV-Living Will

☐OTD-Organ and Tissue Donation

☐PTDEC-Patient refused to discuss advance care planning

☐SDM-Surrogate decision maker present

_____ _____

Patient Signature Date

IRWIN PROFESSIONAL BUILDING

Julia Irwin, MD, Donna Bowers, PA-C,
Russell Koch, PhD, Kimberly Brennan, LPC

Financial Policy

Dear Patient:

Your physician is honored that you have chosen him/her. The following is his/her Financial Policy. His/Her main concern is that you receive the proper and optimal treatments needed. Therefore, if you have any questions or concerns about the payment policies, please do not hesitate to as the Office Manager. All patients are asked to read and sign the Financial Policy as well as complete the Patent Registration form prior to seeing the doctor.

Payment for services is due at the time services are rendered. Your doctor accepts cash, checks, MasterCard, and visa. The office staff will be happy to file your insurance claim for you. However, please be aware that, although your physician has contracts with several insurance companies, he/she is not on all PPO or Network Plans. Please be sure to inquire as to your physician's status with your particular Insurance Company, as this may affect the amount you're responsible for paying.

Please Note: If you are a member of an HMO or Managed Care program and/or have a primary care physician (PCP), you are responsible for contacting your PCP for a referral number prior to your visit, if applicable. If you fail to do so your visit(s) may not be covered by your insurance making you financially liable.

All charges are your responsibility whether your insurance pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment. If the insurance company does not pay your claim with in a reasonable time frame, you will be required to follow up with them and/or pay the balance due in cash, check, MasterCard or visa.

During the course of your Psychiatric Care, it may be necessary for one or more physicians to assist with your medical treatment. You agree to acknowledge that any overpayment or credit balance that you may have with one of the practices with the office is hereby assigned to any of the other practices with the office to which you may have a debt or outstanding balance due. To the extent that you have no balance due to any of the practices within the office upon completion of your medical treatment, any overpayment will be refunded.

Temporary financial problems may affect timely payment of your balance. It is imperative that you communicate such problems to the office manager so that she can assist you in the management of your account.

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor and staff to release all information necessary to secure the payment of benefits.

Again, thank you for choosing your physician as your health care provider. Your physician appreciates your trust and appreciates the opportunity to serve you.

Patient's Signature: _____

Parent/Guardian Signature: _____

Date:_____
Date: _____

CONTROLLED SUBSTANCE POLICY

As part of your treatment, your physician may order medications for you. Many of these medications have serious side effects if they are not managed properly. You will be made aware of any side effects from the medications that we have prescribed for you. Please read the following statement **CAREFULLY** and ask your doctor/nurse if you have any questions.

1. I agree to follow exact dosing instructions prescribed by my physician.
2. I agree to keep all appointments required by my physician. **If I miss an appointment, I understand that a follow-up must be kept before any new prescriptions will be refilled or changed.**
3. I agree to maintain all prescriptions at the same pharmacy, unless reasonable circumstances occur.
4. Refill requests are to be made during office hours only by having your pharmacy contact your provider with a refill request, with at least **75 hours'** notice. No controlled substance will be refilled during evening, weekends or holidays.
5. If a prescription is lost, it will not be refilled early. It your responsibility to keep track of your medications.
6. I agree to submit to a drug screening when asked.
7. I understand that any misuse of my medications will be report to the appropriate authorities and that I can be terminated from the practice.
8. I agree not to get the same class medication from another provider while under this physician's care and understand that if I do, I will be immediately discharged from the practice.

I agree that I have read and fully understand this controlled substance contract. I will as my physicians if I have any questions regarding the potential risk of dependence, addiction and side effects of the medications given to me. I do understand that a breach of this contract will result in my termination from Julia Irwin, MD, Donna Bowers, PA-C

_____

Patient Name & DOB

_____

Patient Signature Date

_____

Pharmacy Name & Phone Number

Julia Irwin, MD PC

Psychiatry
820 Wall Street
Norman, OK 73069
Office: 405-925-2044 Fax: 405-928-2046

INFORMED CONSENT, CONFIEDENTIAL DESCRIPTION OF SERVICES

Description of services: it is my understanding that Julia Irwin, MD, PC., Donna Bowers, MSPA-C, are qualified in Oklahoma to practice medicine. Counseling and medication management involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotion pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for completed sessions.

Confidentiality: All services provided, and all information obtained are kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed such as:

1. A "duty to warn" ethic allows a clinician to break confidentiality when danger exists to the patient or client or others.
2. Under exceptional circumstances, the court may subpoena patient or client's records and may order a clinician to give testimony during a court hearing.
3. Third party payers, such as insurance companies, have a right to review patient or client's records prior to payment.
4. Delinquent accounts may be turned over to a collection agency.
5. Based on clinical judgment, consultation with another professional with respect to your treatment may be sought.
6. Actual or suspected abuse to children or the elderly must be reported to authorities.

Your signature indicates that you have read and understood the above information concerning confidentiality and that you have read and understood the description of services, and consent is given to provide services to you.

_____ _____

Signature Date

OTHER USES OF PSYCHIATRIC INFORMATION.

Other uses and disclosures of psychiatric information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose psychiatric 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 psychiatric information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

I warrant that I have read all terms and conditions of the Patient Privacy Notice and understand that I will be provided a copy upon request.

_____ _____

Signature Date

Phone# (405)928-2044 Fax# (405)928-2046

CONSENT to RELEASE CONFIDENTIAL INFORMATION TO A NON-FACILITY
(EXAMPLE: SPOUSE OR GUARDIAN)

I _____ (CIRCLE) Patient, Parent or Guardian of
(Name of Patient)

_____ SS# _____ DOB _____

(CIRCLE) Select Doctor: **Julia Irwin, MD, Donna Bowers, PA-C,**
Russell Koch, PhD, Kimberly Brennan, LPC

Person you are authorizing us to release information to and/or someone we can talk to about your account, medication or any and all information about your services here.

_____ ▸ Name _____

☐ RELEASE TO Address _____

Phone/Fax _____

Relationship to Patient: _____

☐ EMERGENCY CONTACT:

_____

_____

_____

I hereby acknowledge that this consent for the release of information is given freely. I understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it and that in any event this consent expires in *1YEAR* from the date of signing or upon the condition(s) described above unless a longer period has been specified above.

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPAATITIS, SYPHILIS, GONORRHEA AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). (63 O.S. 1-1502.2 (B)

NOTICE TO INDIVIDUALS OR ENTITIES RELEASING ALCOHOL AND DRUG ABUSE TREATMENT RECORDS

There shall be a statement in bold face, stamped upon each page of the information released stating, "This information has been disclosed to you from records protected by Federal Confidentiality Rules (42CFR Part 2). The Federal Rules prohibit you from making any further disclosures of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for release of medical or other information's is NOT sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

_____ _____
Signature of Client, Parent, Guardian or Authorized Representative when required — Date

_____ _____
Witness — Expires