Collaborative Psych Practitioners

(CPP)

New Patient Packet

Welcome to Collaborative Psych Practitioners! We are excited to assist you on your way to wellness.

The goal of CPP is to help patients achieve their highest level of physical, emotional and spiritual wellness through collaborative mental health solution

Collaborative Psych Practitioners
Benzodiazepine Policy

Benzodiazepines (medications such as Xanax, Ativan, Klonopin, etc.) will **RARELY** be prescribed at CPP, or when prescribed, will be done on a time-limited basis. CPP has decided to make these changes in our prescribing practices to help reduce the growing substance abuse problem in America. Benzodiazepine medications are potentially lethal in accidental overdoses, particularly when mixed with alcohol and/or opioid pain medications. There are also risks associated with dementias as well as interfering and possibly worsening PTSD treatment that are noted with benzodiazepines. Our hope is to ensure the safety and health of all clients seen at this practice.

Some examples of benzodiazepine medications include:

- Ativan (lorazepam)
- Halcion (triazolam)
- Klonopin (clonazepam)
- Librium (chlordiazepoxide)
- Serax (oxazepam)
- Tranxene (clorazepate)
- Valium (diazepam)
- Xanax/Xanax XR (alprazolam)

Please speak with your provider about alternative treatment options.

ADULT ADHD

We treat adult ADHD at CPP in a very conservative fashion. Research shows only 3-5% of those with a childhood diagnosis of ADHD will continue to have this disorder as an adult. Most causes of lack of focus in the adult are a result of mood or anxiety disorders. Please understand even if someone else has previously diagnosed you with adult ADHD, we may choose to not continue any kind of stimulant. Our treatment approach includes making sure all mood/anxiety disorders are under control first, before considering ADHD as an accurate diagnosis. Due to the way stimulants work, these medications may actually exacerbate anxiety, mood and sleep disorders.

For those who are continued on stimulants. A face to face appointment is required before a prescription can be written, and enough medication will be provided until you are seen for your next appointment. Therefore, medication will not be provided between appointments. A follow-up appointment will be made at the end of each office visit, so be sure and bring your calendar to every appointment.

As stimulants are considered CII prescriptions (which indicates they are medications that have a high risk of addiction and misuse; opiate pain medications fall into this same controlled substance category) you likely will be asked to see a therapist to work on strategies to manage ADHD symptoms as the risk of tolerance to these medications is high. Research shows long term benefits of therapy may be superior to stimulant medications.

<u>Replacement prescriptions will not be written for lost or stolen medications in this category</u>. This is to prevent the misuse of medications by clients or their family members. If you need to take doses during the day, take with you only what you need for the day in another container. Never place your prescription medications in checked luggage. Consider putting some of your meds in your carry-on, as well as additional doses of the meds in a deep pocket or the carry-on of a trusted family member.

Medication Refill Policy

Medications will be refilled at medication management appointments.

Refills on medications outside of appointments will rarely be necessary. If they are necessary, patients are asked to request refills from their pharmacy.

Providers will need 5 days notice for all refill requests.

If there is a missed appointment, medication will be refilled until the next scheduled appointment. The next scheduled appointment needs to be within 30 days of the refill. No additional refills will be granted until patient is seen in the office for an appointment.

Notification of scheduled clinic closings will be posted in the clinic to allow patients to make arrangements for refills prior to the clinic closing

I have read and agree to the Medication Refill Policy

_____ _____

Patient/Guardian Signature Date

Holiday Schedule

The clinic will be closed for all major holidays and additional days below:

New Year's Day

Memorial Day

Independence Day

Labor Day

Thanksgiving Day and the day after Thanksgiving

Christmas Eve- closing at noon

Christmas Day and December 26th

New Year's Eve- closing at noon

Clinic Closing Policy

In the event of inclement weather, please watch the local news for the list of local closings.

The clinic will follow the Omaha Public School closing policy.

A sign will be posted in the office, notifying patients of any other scheduled clinic closings.

Emergency Policy

CPP does not provide emergency services.

In the event of a medical or mental health emergencies patients are asked to call 911 or go to the Emergency Department.

I have read and agree to the Clinic Closing and Emergency Policies

_____ _____

Patient/Guardian Signature Date

Patient Communication

Patients will call the clinic phone and leave a voicemail to request a returned call. Providers will return calls within 24 hours during regular office hours.

Calls received after 4:00pm will be returned the following business day.

Telephone messages will be checked during office hours only, Monday-Friday, 9-5pm

In the event of a provider's absence phone calls may be returned by another provider in the office.

Refills should be requested through the pharmacy.

_____ _____

Patient/Guardian Signature Date

Medication Review

Collaborative Psych Practitioner's electronic health record will pull a recent review of all medications from recent pharmacy fills in order to give providers access to most medications prescribed in the last few months.

_____ _____

Patient/Guardian Signature Date

Patient Discharge

Patients will be discharged for 3 no show appointments.

CPP holds the right to discharge patients if the company feels a discharge is warranted.

Examples of situations that may warrant a discharge include,

1. Failure to comply with the patient responsibilities.
2. Any behavior that is disruptive to the clinic, staff or patients.
3. If the clinic is unable to meet the level of care or scope of care the patient requires.

I have read and agree to the patient discharge form

_____ _____

Patient/Guardian Signature Date

Cancellation or No-Show Policy

Cancellations need to be done at least 24 hours prior to patient appointment.

One no-show or cancellation appointment will be allowed before patients will incur a charge of $30.00 per missed appointment without at least 24 hours notice.

Any patient with 3 no-show appointments will be discharged.

Any patient with a lapse in treatment of 6 months or longer with no attempt to schedule a follow up appointment will be discharged. Patient requesting to start services again will be assessed on a case by case basis.

I have read and agree to the Cancellation or No-Show policy

_____ _____

Patient/Guardian Signature Date

New Patient Information

Patient Name: _____ Date: _____

Address: _____

_____

_____

Billing Address (if different): _____

Phone Number: (_____)_____ Detailed voicemail can be left Yes/No

Cell Phone Number: (_____)_____ Detailed voicemail can be left Yes/No

Date of Birth: _____/_____/_____

Gender: _____

Marital Status: (circle) S M W D

Social Security Number: _____-_____-_____

Race: __Native American or Alaska Native ___Asian ___African American

___Native Hawaiian or Other Pacific Islander ___White ___Refuse

Ethnicity: ___Hispanic ___Non-Hispanic ___Refuse

Preferred Language: _____

Primary Care Provider (PCP): _____ PCP Phone Number: _____

Pharmacy:_____

Primary Insurance Holder's Name: _____ Date of Birth:___/___/___

Relationship to Patient: _____

Secondary Primary Insurance Holder's Name: _____ Date of Birth:___/___/___

Relationship to Patient: _____

Employer/Position: _____ Work Phone Number: _____

Under 19, Parent's Name: _____

Emergency Contact Person and relationship: _____

Emergency Contact Phone Number: _____

I hereby give my permission to Collaborative Psych Practitioners (CPP) to administer treatment as may be deemed necessary in the diagnosis and/or treatment of my condition. I hereby authorize my insurance benefits to be paid directly to CPP and the release of any information required by third party payers in claim processing and understand that I am financially responsible for any remaining balance.

Patient/Guardian Signature: _____

If under 19 years of age social security number of parent/guardian:_____-_____-_____

ELECTION AND CONSENT FOR COMMUNICATIONS FORM

I understand that Collaborative Psych Practitioners does not and cannot guarantee the confidentiality of any voicemail messages or email communications and will not be liable for improper disclosure of confidential information and/or breaches in information caused by me or a third party.

I hereby voluntarily request and consent to communicate with my physician and/or office personnel via the following communication methods.

1. Primary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information	2. Secondary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information
3. Tertiary Number: _____ ___Home ___Work ___Mobile ___ Other ___ Doctor name and appointment information ___ Test results ___ Appointment instructions ___ Billing information	4. Primary Email Address: _____ ___Home ___Work ___ Other ___ Appointment instructions

This is to authorize and request that you provide a copy of the results of my procedure(s) to the following:

1. _____

☐ Primary care doctor

☐ Other

2. _____

☐ Primary care doctor

☐ Other

_____ _____ _____

Patient Signature | Patient Printed Name | Date

If Patient is a Minor, has a Legal Guardian or a Power of Attorney exists:

_____ _____ _____

Responsible Party Signature | Responsible Party Printed Name | Date

New Patient Medical Form

Name: _____ Date: _____

Date of Birth: _____/_____/_____

Medical and Mental Health Diagnoses: _____

_____

_____

_____

Surgeries: _____

_____

_____

Medical Allergies: _____

Non-prescription Medications: _____

_____

_____

Prescription Medications (Please include medication, dosage and times taken per day):_____

_____

_____

_____

_____

FORM OF ACKNOWLEDGEMENT

Collaborative Psych Practitioners

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was offered a copy of the Collaborative Psych Practitioners Notice of Privacy Practices effective January 1, 2013.

_____ _____

Printed Name Date

_____ _____

Signature of Patient/Parent/Legal Guardian Relationship to Patient

Note: If signed by someone other than the patient, we need written proof of your authority.

DOCUMENTATION OF GOOD FAITH EFFORT

____ Attempted to distribute the Notice of Privacy Practices to the patient/parent/legal guardian, but the patient/parent/legal guardian declined to acknowledge the receipt of the Notice of Privacy Practices.

____ Patient/parent/legal guardian stated they had already received the Notice of Privacy Practices at another Collaborative Psych Practitioners service location.

____ The Notice of Privacy Practices was mailed to the patient/parent/legal guardian.

_____ _____

Witness Date

Notification of Duty to Warn Policy

Duty to Warn

The duty to warn arises when a patient has communicated an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat.

As mental health practitioners, it is our obligation to warn any identifiable victim.

I have read the Duty to Warn policy

_____ _____

Signature/Guardian Date

Notification of Mandatory Reporting Policy

As healthcare providers, any suspicion of physical, emotional, or sexual abuse or neglect will be reported to Adult or Child Protective Services.

I have read the Mandatory reporting policy.

_____ _____

Signature/Guardian Date

Evaluations for Court

Collaborative Psych Practitioners does not provide evaluations for court.

Referrals can be provided if requested.

_____ _____

Patient/Guardian Signature Date

Financial Agreement Form

Thank you for choosing us as your psychiatric care provider. We are committed to providing you with qualify and affordable mental health care. Some patients have had questions regarding patient and insurance responsibility for services provided, we have developed a payment policy.

Please read and sign the policy. Please ask any questions that may arise. A copy can be provided to upon your request.

1. **Insurance:** We participate in most insurance plans, including Medicare and Medicaid. If you are not insured by a plan we are in business with, payment in full is expected at each visit. If you are insured by an insurance plan we are in business with but do not have an up-to-date insurance card, payment in full is required until we can verify your insurance benefits. Knowing your insurance benefits is your responsibility. Please contact your insurance plan with any questions regarding your coverage.
2. **Copayments and deductibles:** All copays and deductibles must be paid prior to your appointment. This arrangement is part of your contract with your insurance company. **Failure on our part to collect copays and deductibles is considered fraud.** We want to ensure we are upholding the law, so please ensure you come with your copay or deductible at each visit.
3. **Non-Covered Services:** Please be aware that some and perhaps all services could be considered noncovered, unreasonable, or unnecessary by Medicare or other insurers. You are responsible for payment in full of any services provided regardless if these services are covered by your insurance.
4. **Proof of Insurance:** All participants must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and valid insurance card to provide proof of insurance. If you fail to provide the correct insurance information in a timely manner. You may be responsible for the balance of a claim.
5. **Claims Submission:** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not the insurance company pays for the claim. Your insurance benefit is a contract between you and your insurance company.
6. **Coverage Charges:** If your insurance changes please contact the office before your next visit so we can make the appropriate changes and help you receive your maximum benefits. If your insurance company does not pay for services in 45 days, the balance will automatically be billed to you.
7. **Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless an agreement has been made with Collaborative Psych Practitioners. Please be aware that if a balance remains unpaid, we may refer your

account to a collection agency and you and your immediate family members may be discharged. If this is to occur you will be notified by certified mail to find alternative psychiatric care. During the 30 day period our providers will only be able to treat you on an emergency basis.

8. **Missed appointments:** Our policy is to charge you for missed appointments without notice and those appointments canceled without 24 hour notice. These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges in our area.

Thank you and please contact the office with any questions.

I have read and understand the payment policy and agree to the guidelines listed above.

_____ _____

Signatures of patient/guardian Date

Collaborative Psych Practitioners Telemedicine Patient Consent/Refusal form

Patient Name_____

Patient Date of Birth_____

1. PURPOSE: The purpose of this form is to obtain your consent to participate in telemedicine consultation in connection with the following procedure(s) and/or service(s)

   _____
   _____Medication Management_____
   _____
2. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   a. Details of your medical history, examinations, lab testing, psychological testing will be discussed through the use of interactive video, audio and telecommunication technology.
   b. You may be asked to have your Vital signs taken including blood pressure, pulse, weight, height and reported during your visit.
   c. Video, audio, and/or photo recordings may be taken of you during the procedure(s) or services.
3. MEDICAL INFORMATION AND RECORDS: All existing laws regarding your access to medical information and copies of your medical records apply to telemedicine consultation. Please note, not all communications are recorded or stored. Additionally, dissemination of any patient identifiable images or information for this telemedicine interaction to researchers or other entities shall not occur without your consent.
4. CONFIDENTIALITY: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associates with telemedicine consultation, and all existing confidentiality protections under federal and Nebraska state apply to information disclosed during this telemedicine consultation.
5. RIGHTS: You may withhold and withdraw consent to the telemedicine consultation at any time without affecting your right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
6. DISPUTES: You agree that any dispute arriving from the telemedicine consult will be resolved in Nebraska and that Nebraska law shall apply to all disputes.
7. INSURANCE AND PAYMENT: I understand that any balance due after insurance is filed is my responsibility.
8. RISKS, CONSEQUENCES, AND BENEFITS: You have read the information attached on all potential risks, consequences and benefits of telemedicine. You have had the opportunity to ask questions about the information presented on this form and the telemedicine consultation. You understand the written information provided above.

I agree to participate in a telemedicine consultation for the following procedures described above.

Signature:_____

If Signed by someone other than the patient, indicate the relationship: _____

Date:_____ Time:_____

Collaborative Psych Practitioners telemedicine informed consent

INFORMED CONSENT FOR TELEMEDICINE SERVICES

INTRODUCTION

Telemedicine involves the use of electronic communication to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Telemedicine is especially useful in situations in nature disasters when accessing a medical office is not possible. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devises and sound and video files

Electronic systems used will incorporate network software security protocols to protect the confidentiality of patient identification and imaging data and will include measure to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPTECTED BENEFITS

- Improved access to medical care enabling the patient to remain in his/or her home while the medical provider provides medical evaluation, assessment and treatment.
- Allows for access to care in emergency situations when traveling to a medical office is not possible.

POSSIBLE RISKS

As will any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but are not limited to:

- In rare cases, information transmitted may not be sufficient (ex. Poor resolution of audio or images) to allow for appropriate medical decision making by the nurse practitioner or consultant.
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to complete medical records, or medical assessment may result in adverse drug interactions, allergic reactions or other judgement errors.

AUTHORIZATION FORM
AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

1) ☐ **Authorization for Release/ Receive information.** The undersigned hereby authorizes Collaborative Psych Practitioners and its employees to use and/or disclose/ and receive protected health information from/to:

_____

For the following purpose(s) (may state "per my request"): _____

The following health information:

☐ Entire medical record

☐ Entire medical record, excluding:

- ☐ Health information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus)
- ☐ Health information relating to sexually transmitted diseases
- ☐ Mental health records
- ☐ Drug and/or alcohol abuse records

☐ Other (specify) _____

2) **Conditions.** We may not condition your right to receive health care services from us upon your signing this authorization. However, if the treatment to be provided is for research purposes, your failure to sign this authorization will prevent us from providing such treatment.

3) **Further Uses and Disclosures.** When we use or disclose your health information as you have instructed us in this authorization, we do not have the ability to monitor whether your health information may be further used or disclosed by such parties. In such a situation, your disclosed health information may no longer be protected by Federal and State privacy laws.

4) **Expiration.** This authorization shall expire upon the earlier of _____ or twelve (12) months from the date of this authorization. After the expiration date, we will need to obtain a new authorization from you if required by law.

5) **Revocation.** You have the right to revoke this authorization at any time by providing us with written notice by certified mail or hand delivery to the following address:

Collaborative Psych Practitioners
ATTN: Kimberly Camp-Grimit
18049 Oak St.
Omaha, NE 68130

When we receive your revocation, we will immediately stop using and disclosing the health information you authorized us to use and disclose in this authorization form. Your revocation shall not apply to those uses and discloses we made on your behalf pursuant to this authorization prior to the time we received your written revocation.

_____ _____

PRINTED PATIENT NAME PATIENT DATE OF BIRTH

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE

***NOTE: IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, WE MUST HAVE WRITTEN PROOF OF HIS/HER AUTHORIT**