Crescent City Psychiatric, LLC

Consent to Evaluate and Treat

Date: _____

Patient_____ Age: _____ Date of Birth: _____

Social Security Number: _____

Gender: Male____ Female____

Phone number you would like to be contacted at: _____

Home Address: _____

City, State, Zip Code: _____

Email: _____

Pharmacy Name: _____ Pharmacy Number: _____

How did you hear about us? Friend____ Family member____ Health care provider____

Internet Search___ Other (please explain):_____

Please complete the following if the person responsible for payment is someone other than patient:

Name: _____

Relationship to patient: _____

Gender: Male____ Female_____

Address (if different from the patient)_____

City, State, Zip Code: _____

Phone number you would like to be contacted at: _____

*****I authorize Crescent City Psychiatric to evaluate and treat:**

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Crescent City Psychiatric, LLC

Notice of Patient Rights and Responsibilities

As a patient at Crescent City Psychiatric, you have the right to privacy and confidentiality regarding your health care. Thank you for giving me the opportunity to best serve your needs, and for allowing me to provide mental health services to you.

As a patient, you have the following rights:

1) The Right to Privacy and Confidentiality: All records and communication regarding your health information will be kept secure and be kept confidential in compliance with state and federal laws. Under state and federal, there may times when confidentiality may have to be broken and health information disclosed to certain parties. This includes cases of those who pose a danger to themselves or others, domestic violence, suspected abuse or neglect. We may also be mandated to report your health information by court order, or when it is necessary to prevent or lessen a series imminent threat to the health or safety of a person or public. With your authorization, we may also use and disclose your health information to insurance or managed care companies for payment of services. This may include submitting a diagnoses which describes a mental disorder that you or your child may meet the criteria for under the DSM-IV-TR or DSM-V. This information may be accessed via paper claims or electronic claims that I submit directly to your insurance company or may be stored in an electronic based system that other insurance companies may access when we apply for a certain insurance panel. If you do not wish to release this information, you must then pay cash for services rendered.
2) The Right to Medical Records: You may request a copy of your medical records pertaining to your treatment. A reasonable copy fee may be applied.
3) The Right to Account Information: You may request an accounting of certain disclosures that is made of your health information. A reasonable fee may be applied.
4) The Right to Clear Instructions and Up-to-date Information: We will make it a priority to clearly explain you or your child's diagnosis, discuss prognosis, discuss treatment options, discuss the of risks and benefits of treatment(s), discuss the nature and purpose of certain tests and procedures, prescribe therapy or medications, order laboratory tests, provide the need for follow-up visits, recommend other mental health or medical professionals as referrals, and discuss any additional measures to achieve desired outcomes for you or your child's diagnoses.
5) The Right to Accept or Refuse Treatment Recommendations
6) The Right to Seek Additional Professional Opinions
7) The Right to a Safe Environment
8) The Right to Professionalism and Courtesy
9) The Right to Continuation of care—Please note that we will refer you to another practicing mental health provider, mental health clinic/hospital, or emergency service(s) in the event that a provider at Crescent City Psychiatric is not available to treat you or no longer available to treat you upon termination of care

As a patient, you have the following responsibilities:

1) Contact your treatment provider for any serious situation that arises, even after normal office hours
2) Provide correct, and complete information about your health
3) Follow the treatment plan to achieve your treatment goals
4) Advise your treatment provider of any changes in your health condition
5) Be respectful the rights of other patients and building/office personnel
6) Arrive for your scheduled appointment on time and call the office if you are unable to make your appointment
7) Meet the financial obligations for your care as soon as possible

*****By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information.**

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Crescent City Psychiatric, LLC

Financial Policy Agreement and Appointment Adherence Agreement

1. Patients without insurance: All patients without insurance are required to pay in full for the service rendered at the time of the appointment. Refunds will not be issued under any circumstances.
2. All patients with managed care plans: It us your responsibility to know and understand your managed care plan. Generally, these plans require payment of deductibles and/or copayments. Patients are required to pay for services according to their insurance contract at time of service.
3. All patients with insurance: If our office is contracted with your insurance company, we will file your insurance claims if you provide us with the proper information along with a copy of your current insurance card. In the event your insurance overpays, we will refund the overpayments to you promptly upon written request. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and you will be billed accordingly.
4. Cancelation policy: There is a $75 charge for failed appointments/late cancellations of appointments **when less than a 48 business hours' notice** is given by the patient. Normal business hours are Monday through Thursday, 8am to 4pm, and Friday 8am to 12pm. For example, if an appointment is for a Monday, patient must call to cancel their appointment by 4pm at the latest on the previous Thursday to avoid the late cancelation fee. **Reminder calls and emails to our patients are offered as a courtesy only.**
5. We have the right to discharge clients at any time. However, patients who miss more 2 or more appointments without 48 hour notification, or are 10 minutes or more late for their scheduled appointments on 2 or more occasions, will be discharged automatically and mailed a written letter of the notification. Medications may be refilled for a one month supply if appropriate.
6. Questions: You are encouraged to call our office if there are any questions about this information. If at any time during the treatment of the patient and financial problems arise, you are encouraged to speak with our office.
7. Payment for services rendered can be made by cash or checks written out to Crescent City Psychiatric, LLC.
8. Checks that are not cleared by the bank for any reason will be assessed a $30 service charge. You will be asked to bring cash, certified check or money order to cover the amount of the check and the service fee. All bad checks written at the office are subject to collection action and will be prosecuted by Jefferson Parish District Attorney's office.

*****By signing below, you acknowledge that you have read, understood, and agreed with the above policies and information.**

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Crescent City Psychiatric, LLC

Prescription Medication Policy

1. If a patient has questions, concerns, adverse effects from a medication, it is the patient's responsibility to notify our office with any concerns. If patient receives our voicemail, a message should be left including the patient's name, DOB, and the question or concern that patient is having. Our staff will then return your call ASAP. If patient is having an emergency, patient is advised to call 911 or visit their nearest urgent care or emergency room.
2. Patient should call 911 or visit their local emergency room for an emergency. Examples of an emergency include but are not limited to: patient having thoughts of hurting self or others, patient concerned about worsening of symptoms, patient concerned of having or experiences effects from abruptly stopping their medication at any time during treatment or after treatment has been terminated.
3. A patient should seek care from an urgent care, emergency room, or their general practitioner in the event where the patient expects to be without their prescribed medication, and he or she feels they cannot wait until their next scheduled appointment with Crescent City Psychiatric to obtain their prescribed medication.
4. Crescent City Psychiatric in under no obligation to continue prescription medications and may terminate care if the patient does not follow the recommended treatment plan and/ or adjusts his or her medications on their own at any time without consulting with Crescent City Psychiatric.
5. Patients with insurance are responsible for knowing which medications may or may not be covered by their insurance plan.
6. Patient acknowledges that availability of appointments are limited and patient is solely responsible for scheduling their follow-up appointments in a timely manner to ensure he/she will have enough medication to last until their next scheduled appointment ("timely manner" is defined as no longer than 24 business hours after being seen by their provider for an appointment).
7. Patient should call or leave a voicemail for refill requests or prior authorizations (PA). Patients are responsible for knowing the medication name, dose, and directions of their medication.
8. Patients are not to rely on their pharmacy to submit refill requests or PA requests. Pharmacy refill requests will be denied until we first hear from the patient that a refill is being requested. After an official request is made, please allow 3 business days for staff authorize the refill or initiate a PA.
9. A refill request by a patient does not guarantee that the medication will be approved for a refill.
10. Patient must have had at least one follow-up visit with their provider at Crescent City Psychiatric to assess the response and possible side effects of the medication before a refill will be authorized.
11. Patient refill requests will be denied unless a patient already has an appointment scheduled with their provider.
12. A refill may be authorized for a non-controlled substance for 30 days for patients who missed their appointment due to an illness or emergency ONLY if the patient has already seen a provider at Crescent City Psychiatric for at least ONE follow-up visit in which the provider has been able to assess the response of prescribed medication and thus has continued the prescribed medication.

*****By signing below, you agree that you have read and understand the Prescription Medication Policy**

Patient Name: _____ Date of Birth: _____

Signature of Patient: _____ Date: _____

Credit Card Consent Policy Form

I, the undersigned, authorize Crescent City Psychiatric to keep my signature on file and to charge my credit/debit card account as indicated below:

A charge to the credit/debit card will be made under the following circumstances:

1. *Missed appointments
2. *Cancellations made less than 48 hours from time of scheduled appointment
3. Payments/copayments made at the time service is rendered
4. Unpaid balances after 30 days from the date of service

*Missed Appointment/Late Cancelation Fee: $75 (In order to cancel your appointment without being charged the $75 fee, you must contact Crescent City Psychiatric via phone or email no later than 48 business hours prior to the appointment time)

*****I, the undersigned, understand that this form will be valid for the duration of my treatment with this office UNLESS I cancel through written notice to Crescent City Psychiatric, 3045 Ridgelake Dr. Suite 102, Metairie, LA 70002. I also understand that refunds will not be issued under any circumstance, unless you card is charged by mistake or overcharged. I also understand that a service charge of 4% may be assessed for each payment used with a credit/debit card.**

_____ _____

Patient Name Cardholder Name

Card Type: Visa_____ MasterCard_____ Discover_____ Amex_____

Credit Card Number_____

Name as appears on Card _____

Client Name (If different from name on card) _____

Expiration Date (mm/yyyy) _____

Security Code (Usually the 3 digit ID on the back of card)_____

_____ _____

Cardholder Signature Date