

**Plaza West Psychiatrists
Registration Form**

Date _____

Patient Name _____

DOB ____ / ____ / ____

Social Security Number _____ Marital Status _____

Gender M / F

Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ Reminder Call Preference H / C

How would you like to receive Appointment Reminders? Phone Call / Text / Email

Email Address: _____ Would you like access to our patient portal Y / N

Race _____ Ethnicity _____ Preferred Language _____ Religion _____

Employer _____ If Full Time Student, School _____

Primary Care Physician _____

Guarantor/Parent/Spouse/Other Relationship to Patient Information

Name _____ Relationship to Patient _____ DOB ____ / ____ / ____

Social Security Number _____ Phone _____

Address _____ City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Information

Please present all insurance cards to receptionist

Primary Insurance _____ Policy/ID# _____ Effective Date _____

Subscriber's Name _____ Subscriber's Relationship to Patient _____

Subscriber's Social Security Number _____ DOB ____ / ____ / ____

Secondary Insurance _____ Policy/ID# _____ Effective Date _____

Subscriber's Name _____ Subscriber's Relationship to Patient _____

Subscriber's Social Security Number _____ DOB ____ / ____ / ____

Authorize and Release

I certify the above information is correct to the best of my knowledge. I authorize the provider to release any information including the diagnosis and the records for any treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the provider's office insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual billed services and that I am ultimately responsible for any unpaid balances. I understand and agree that this office may leave messages for me on the phone numbers provided by myself/guardian.

Signature of Patient/Parent or Guardian _____

PLAZA WEST PSYCHIATRISTS

2222 S 16th St, Suite 410, Lincoln, NE 68502, Ph: 402-474-1511, Fax: 402-474-1611

Jose Gary Nadala, MD

Lisa Young, MSN, APRN, BC

Helen Trotter, MSN, APRN, BC

Nathan Warner, MSN, APRN, BC

PLAZA WEST INTEGRATED HEALTH

Eileen Warner, MSN, APRN, BC

Patient Bill of Rights

Patient Name _____

DOB ____ / ____ / ____

As patient you have the right to:

- Be treated with dignity and respect.
- Not be discriminated against on the basis of race, age, sex, religion, national origin, sexual orientation, disability, or marital status.
- Include or exclude family members/significant others in all aspects of your care
- Participate fully in decisions regarding your treatment plan
- Understand the treatment(s) being used, as well as their benefits and consequences
- Refuse Treatment, unless ordered by the Court to participate
- To receive an explanation and understand the benefits and/or side effects associated with prescribed medications
- Not be subjected to verbal, physical, sexual, emotional or financial abuse; harsh or unfair treatment.
- Make complaints, have them heard, get a prompt response, and not receive any threats or mistreatments as a result.
- Waive the privilege of confidentiality with a signed release of information
- Confidentiality to the extent of the law; exceptions include suspected child/elder abuse/neglect, potential harm to oneself or others, court ordered treatment and court subpoena records
- Clear understanding of fees associated with care

As a patient you have the responsibility to:

- To disclose your medical history throughout your course of treatment
- To treat others with dignity and respect
- Assume financial responsibility for treatment
- To follow medical advice, treatment and drug instructions or notify provider if you have chosen not to take that advice
- To keep scheduled appointments or to cancel at least 24 hours in advance

Signature of Patient/Parent or Guardian _____

Date _____

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Informed Consent to Treatment

This form is to document that I, _____, **(your name)** give my permission and consent to **Plaza West Psychiatrists** to provide mental health services to me or give my consent for the minor or person under my legal guardianship _____ **(patient name)**.

While I expect benefits from this treatment I fully understand that because of factors beyond our control or other factors, such as benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changed which could be distressing.

I understand that this provider is not providing an emergency service and I have been informed of whom to call upon in emergency or during weekend and evening hours.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective planning or continued care can be implemented.

I understand that conversations with the provider will almost always be confidential. I further understand that the provider by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the provider has a legal responsibility to protect anyone I may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the provider will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my insurance.

I know of no reasons I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature of Patient/Parent or Guardian _____ **Date** _____

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Informed Consent to use Patient Portal

*this is an optional form, if you do not wish to participate please leave blank

Patient Name _____ DOB ____/____/____

Email Address: _____

Purpose: Plaza West Psychiatrists offers a secure way for our patients to view parts of their records and communicate with our staff. Secure messaging can be a valuable communications tool, but has certain risks. In order to manage these risks we need to impose some conditions of participation. This form is, therefore, intended to show that you have been informed of these risks and the conditions of participation, and that you accept the risks and agree to the conditions of participation.

How It Works: A secure web portal is a kind of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site.

How To Participate: You can compose, pickup and reply to secure messages or view information sent to you through a website hosted by our electronic health records company. Once this form is agreed to and signed, we will send you an email notification that tells you how to register for the first time. This notification will give you the URL (internet address) of the website where you can log in. By clicking on the URL you will activate your internet browser, which will open the website. You will then be able to log in using the user name and password provided. Next you will be able to look in your "message box" and see any new or old messages or view other parts of your electronic record. Because the connection channel between your computer and the website uses "secure sockets layer" technology, you can read or view information on your computer but it is still encrypted in transmission between the website and your computer.

You Can Access The Portal Through: patientonlineportal.com

Privacy Protection And Risks: This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. However, keeping message secure depends on two additional factors: the secure message must reach the correct address and only the correct individual (or someone authorized by that individual) must be able to get access to it. Only you can make sure these two factors are present. We need you to make sure we have your correct email address and we are informed if it ever changes. You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. If you think someone has learned your password, you should promptly go to the website and change it. We understand the importance of privacy in regards to your health care and will continue to strive to make all the information as confidential as possible. We will never sell or give away any private information, including email addresses, without your written consent.

Conditions of Participation: Use of the Patient Portal and appendix is governed by the terms and conditions of this informed consent and the policies and procedures. Please read this agreement carefully before accessing or using the Patient Portal. Access to this secure site is an optional service, and we may suspend or terminate it at any time and for any reason. We reserve the right at any time and from time to time to modify the Patient Portal site or documents or any part thereof, with or without notice. Any modifications made to this document or its appendix will be effective immediately upon posting on the site. By accessing or using the Patient Portal, you agree to be bound by all the terms and conditions of the Patient Portal as posed on the site at the time of your access or use. You agree to review the Patient Portal documents on the website each time you use the Patient Portal so that you are aware of any modifications made to the Patient Portal documents. You agree not to hold Plaza West Psychiatrists or any of its staff liable for network infractions beyond its control. All site users represent and warrant that they are at least 18 years of age and that they possess the legal right and ability to agree to these terms of participation as set out in the Patient Portal documents and to use the site in accordance with these documents. We are offering this service free of charge until the end of the year at which time we reserve the right to charge an annual fee. We will provide adequate notice of such fees prior to them taking affect.

Before you were given this form, we provided you with our policies and procedures for using the Patient Portal. We need you to understand and comply with these, and by signing this form below you will acknowledge that they were explained to you and that you agree to comply with them. If you do not understand or do not agree to comply with our policies and procedures, do not sign this form. If you have any questions we will gladly provide more information.

Patient Acknowledgment

Signature of Patient/Parent or Guardian _____ Date _____

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Acknowledgement of Privacy Practices

Use and Disclosure of Your Protected Health Information

Your protected health information will be used by Plaza West Psychiatrists or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices

Plaza West Psychiatrists is required to notify you of our privacy practices. Additionally, we must provide you information on how you may get access to this information. These policies and practices are defined in the “Notice of Privacy Policies and Practices” posted in the office and available upon request. **Please review it carefully.**

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your protected health information. Plaza West Psychiatrists may or may not agree to restrict the use or disclosure of your protected health information.

If Plaza West Psychiatrists agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Reservation of Right to Change Privacy Practices

Plaza West Psychiatrists reserves the right to modify the privacy practices outlined in the notice. I understand that Plaza West Psychiatrists will notify me of these changes via the method I have authorized or upon my next appointment.

Signature

I have reviewed this consent form, reviewed the posted “Notice of Privacy Policies and Practices” and give my permission to Plaza West Psychiatrists to use and disclose my health information in accordance with this consent and the notice provided.

Signature of Patient/Parent or Guardian _____

Date _____

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Important Patient Information

Thank you for choosing Plaza West Psychiatrists. As a healthcare provider our goal is to improve the quality of life by providing exceptional mental health care. Upon the initial visit, you will meet with and discuss with your provider your history, reasons for initiating care and establishing a treatment plan best suited to your needs. Patients are asked to be as open as possible with their provider. We can better serve your health care needs if you are familiar with the following policies and procedures.

Office Hours & Appointments

Our office is open Monday through Friday from 8:00 a.m. to 6:00 p.m. Our telephone hours are 9:00 a.m. to 6:00 p.m. After hour calls are handled by our answering service, who do have the capability of reaching provider in the event of an emergency. Follow up appointments should be made prior to leaving the office. The frequency of the appointments is determined by your provider. Typically, Follow up Appointments for Medication Management are 15 minutes and Therapy Appointments 1 Hour. Appointments may also be scheduled by calling 402-474-1511. It is the patient responsibility to arrive on time for their appointment, if you are more than five minutes late you will be asked to reschedule. Appointments should be canceled no later than 24 hours prior to the scheduled appointment time. Patients no showing three or more appointments are subject to termination. Please note in the event of inclement weather Plaza West Psychiatrists follows the closure procedure of Southeast Community College.

Insurance and Financial Responsibility

It is up to you as a patient to provide us with current Insurance Information, as a courtesy we will bill medical claims to your insurance company. Monthly billing statements are generated and payment is due 30 days from receipt. Payment arrangements can be made on balances by calling our Billing Specialist at 402-474-1511 ext 3. All Copayments are due at time of service. Patients without insurance will be asked for payment in full prior to the scheduled appointment. If your account balance is unpaid and past due we will make three attempts at contacting you, if you fail to respond your account will be referred to a collection agency. Any balances listed at a collection agency must be paid in full prior to scheduling another appointment at our office.

Prescription Refill Requests

Medication refills requiring a written script should be requested during your appointment or may be requested by calling us at 402-474-1511. For all other medications, please call your pharmacy to request. Please allow us 24 hours to fulfill your refill request. Please note medications sometimes require a prior authorization from your insurance company, once we have received the proper paperwork from your pharmacy we will initiate the prior authorization which may take up to **3-4 days**. Patients who have failed to make or have missed appointments, run the risk of refill requests being denied. Please call our office to report a medication side effect or any worsening conditions. If you encounter a true medical emergency, call 911.

I have read and understand all above policies

Signature of Patient/Parent or Guardian _____

Date _____

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Authorization for Disclosure of Health Information

We need a form completed for each person you would like us to disclose your information to

Medicaid Patients must complete this form for your Primary Care Provider, if you do not have a Primary Care Provider please write None and complete

Patient Name _____ DOB ____ / ____ / ____

Social Security Number _____ Date of Consent _____

Hereby Authorize: Plaza West Psychiatrists

To Receive _____ To Release _____ Protected Health Information To/From:

Name of Health Care Provider/Agency/Plan/Other

Address City, State, Zip Code Phone Number Fax Number

INFORMATION TO BE DISCLOSED: (please check all that apply)

- Entire Record
- Psychological Evaluation
- History & Physical Examination
- Other (Specify): _____
- Psychiatric Evaluation
- Consultations
- Termination Summary
- Laboratory Reports
- Prescriptions
- Treatment Plan
- Substance Use Assessment

REASON FOR DISCLOSURE: (please check all that apply)

- Request of Patient
- Obtaining past treatment records
- Other (Specify) _____
- Collaboration of Care
- Changing Providers
- Legal Purposes
- Consultation and/or Treatment

I understand that I may revoke this authorization at any time in writing or it will automatically expire 12 months from the date signed. By signing this Authorization, I acknowledge that the information to be released may include material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Plaza West Psychiatrists from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (fax) copy shall have the same effect and authority as the original copy.

Signature of Patient/Parent or Guardian _____ Date _____

Witness: _____

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Telehealth Patient Consent Form

Patient Name _____

DOB _____

Provider(s) Name _____

I agree to receive this health care service, as a telehealth service. I understand that the health care practitioner is located at Plaza West Psychiatrists 2222 S 16th St Ste 410 Lincoln NE 68502.

A telehealth service means that my visit with a practitioner at the distant site will happen by using special audiovisual equipment. This consent is valid for the duration of treatment with Plaza West Psychiatrists.

I also understand that:

- I can decline the telehealth service at any time without affecting my right to future care or treatment, and any program benefits to which I would otherwise be entitled cannot be taken away.
- I may have to travel to see a health care practitioner in-person if I decline the telehealth service.
- The same confidentiality protections that apply to my other medical care also apply to the telehealth service.
- I will have access to all medical information resulting from the telehealth service as provided by law.
- The information from the telehealth services (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone without my additional written consent.
- I will be informed of all people who will be present at all sites during my telehealth service.
- I may exclude anyone from any site during my telehealth service.
- I have read this document carefully, and my questions have been answered to my satisfaction.

Signature of Patient/Parent or Guardian _____ **Date:** _____

Please email back to pwp@plazawestpsychiatrists.com