Plaza West Psychiatrists
Updated 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 providers 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_____

Revised 10-2018

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

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 ___ Psychiatric Evaluation ___ Laboratory Reports ___ Treatment Plan

___ Psychological Evaluation ___ Consultations ___ Prescriptions ___ Substance Use Assessment

___ History & Physical Examination ___ Termination Summary

___ Other (Specify):_____

REASON FOR DISCLOSURE: (please check all that apply)

___Request of Patient ___Collaboration of Care ___ Legal Purposes ___Consultation and/or Treatment

___ Obtaining past treatment records ___Changing Providers

___Other (Specify) _____

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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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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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**