COMMUNITY AND LONG-TERM CARE PSYCHIATRY, L.L.C.
10004 Kennerly Rd, Ste 362B, St. Louis, MO 63128; Phone 314-525-5050, Fax 314-525-5072

NEW PATIENT INFORMATION FORM

All information is subject to the Consent to Release PHI and the Notice of Privacy Practices

PATIENT INFORMATION Today's Date:_____

Name: _____ Date of Birth:_____
Last First MI mm/dd/yyyy

Address: _____
Street Address City State Zip Code

CONTACT INFORMATION: (Please circle preferred method of contact for appointment confirmation.)
Do you authorize us to leave a message on your voice mail/answering machine? ____ Yes ____ No

Home Phone:_____ Cell Phone: _____

Work Phone: _____ Email: _____

INSURANCE INFORMATION: If same as patient check this box ☐ then skip to Emergency Contact

Name of INSURED: _____ Date of Birth_____
Last First MI mm/dd/yyyy

Address of Insured:_____
Street Address City State Zip Code

Patient Relationship to Insured _____
Self, Spouse, Child, Other

Primary Insurance: _____ Policy # _____

Group # _____ Effective Date: _____

Secondary Insurance: _____ Policy # _____

Group # _____ Effective Date : _____

EMERGENCY CONTACT INFORMATION:

Contact Name: _____ Phone: _____

Relationship to Patient: _____

PREFERRED PHARMACY:

Pharmacy: _____ Phone: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Phone:_____

Address: _____
Street Address City State Zip Code

REASON FOR EVALUATION TODAY: _____

I WAS REFERRED BY: _____

I, _____ authorize the medical treatment by a Community and Long-Term Care Psychiatry, L.L.C.

I have given to Community and Long-Term Care Psychiatry, L.L.C. consent to release protected health information (PHI).

I acknowledge full financial responsibility for services rendered by Community and Long-Term Care Psychiatry, L.L.C. I understand that payment is due at the time of service and agree to pay all reasonable attorney fees and collection costs in the event of default of payment of my charges.

I further understand and agree that in case I do not show up or call less the 24 hours before an appointment to cancel or reschedule, I will be charged a fee according to Community and Long-Term Care Psychiatry, L.L.C. policies. I understand that this fee is not covered by my insurance and will be billed directly to me as it is my sole responsibility.

_____
Printed name of Patient

_____ _____
Signature of Patient, Guardian or POA Representative Date

PATIENT HISTORY FORM

Date:_____ Age: _____ Sex: __ Female __ Male

Name: _____ DOB: _____
Last First MI mm/dd/yyyy

How did you hear about this clinic? _____

Describe briefly your present symptoms:_____

_____

Please list the names of other practitioners you have seen for this problem: _____

_____

Psychiatric Hospitalizations (include where, when, and for what reason):_____

_____

_____

Have you ever had ECT? __ Yes __ No Have you had psychotherapy? __ Yes __No

CURRENT MEDICATIONS:

Drug allergies: __ No __Yes and to what _____

Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

Name of drug	**Dose (include strength & # of pills per day)**	**How long have you been taking**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

PAST MEDICAL HISTORY

Do you now or have you ever had:

__ Diabetes
__ High blood pressure
__ High cholesterol
__ Hypothyroidism
__ Goiter
__ Cancer (type)_____
__ Leukemia
__ Psoriasis
__ Angina
__ Heart problems
__ Heart murmur
__ Pneumonia
__ Pulmonary Embolism
__ Asthma
__ Emphysema
__ Stroke
__ Epilepsy
__ Cataracts
__ Kidney disease
__ Crohn's disease
__ Colitis
__Anemia
__ Jaundice
__ Hepatitis
__ Stomach or peptic ulcer
__ Rheumatic fever
__ Tuberculosis
__ HIV/AIDS

Other medical conditions (please list): _____

_____

_____

PERSONAL HISTORY

Where there problems with your birth? (specify) _____
Where were you born and raised? _____
What is your highest education? __ high school __ some college __ college graduate __ advanced degree
Marital status: __ never married __ married __ divorced __separated __ widowed __ partnered/sig other
What is your current or past occupation?_____
Are you currently working? __Yes __No Hours/week ___ If not, are you __retired __disabled __sick leave
Do you receive disability or SSI? __Yes __No If yes, for what disability & how long _____

_____

Have you ever had legal problems? __Yes __No If yes, specify _____

_____

Religion: _____

FAMILY HISTORY

	IF LIVING		**IF DECEASED**	
	Age	**Health & Psychiatric**	**Age at death**	**Cause**
Father	_____	_____	_____	_____
Mother	_____	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:
Maternal Relatives:_____

_____

Paternal Relatives:_____

_____

SYSTEM REVIEW

In the past month, have you had any of the following problems?

GENERAL
__ Recent weight gain: how much ___
__ Recent weight loss: how much ___
__ Fatigue
__ Weakness
__ Fever
__ Night sweats

MUSCLE/JOINTS/BONES
__ Numbness
__ Joint pain
__ Muscle weakness
__ Joint swelling
Where?_____

EARS
__ Ringing in ears
__ Loss of hearing

EYES
__ Pain
__ Redness
__ Loss of vision
__ Double or blurred vision
__ Dryness

HEART AND LUNGS
__ Chest pain
__ Palpitations
__ Shortness of breath
__ Fainting
__ Swollen legs or feet
__ Cough

NERVOUS SYSTEM
__ Headaches
__ Dizziness
__ Fainting/loss of consciousness
__ Numbness or tingling
__ Memory loss

STOMACH/INTESTINES
__ Nausea
__ Heartburn
__ Stomach pain
__ Vomiting
__ Yellow Jaundice
__ Increasing constipation
__ Persistent diarrhea
__ Blood in stools
__ Black stools

SKINS
__ Redness
__ Rash
__ Nodules/bumps
__ Hair loss
__ Color changes of hands/feet

BLOOD
__ Anemia
__ Clots

KIDNEY/URINE/BLADDER
__ Frequent or painful urination
__ Blood in urine

PSYCHIATRIC
__ Depression
__ Excessive worries
__ Difficulty falling asleep
__ Difficulty staying asleep
__ Difficulties with sexual arousal
__ Poor appetite
__ Food cravings
__ Frequent crying
__ Sensitivity
__ Thoughts of suicide/attempts
__ Stress
__ Irritability
__ Poor concentration
__ Racing thoughts
__ Hallucinations
__ Rapid speech
__ Guilty thoughts
__ Paranoia
__ Mood swings
__ Anxiety
__ Risky behavior

THROAT
__ Frequent sore throats
__ Hoarseness
__ Difficulty swallowing
__ Pain in jaw

Women Only
__ Abnormal Pap smear
__ Irregular periods
__ Bleeding between periods
__ PMS

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:
Age of first period: ____ Number of miscarriages: ____ Number of abortions: ____
Have you reached menopause __ Yes __ No If yes, what age? ____
Do you have regular periods? __ Yes __ No

SUBTANCE USE

DRUG CATEGORY (circle each substance used)	Age when you first used this	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					
CANNABIS Marijuana, hashish, hash oil					
STIMULANTS Cocaine, crack					
STIMULANTS Methamphetamine - speed, ice, crank					
AMPHETAMINES/OTHER STIMULANTS Ritalin, Benzedrine, Dexedrine					
BENXODIAZEPINES/TRANQUILIZERS Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					
SEDATIVES/HYPNOTICS/BARBITURATES Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					
HEROIN					
STREET OR ILLICIT METHADONE					
OTHER OPIOIDS Tylenol #2 & #3, 282's, 292's, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					
HALLUCINOGENS LSD, PCP, STP, MDA, DAT, Mescaline, Peyote, Mushrooms, Ecstasy (MDMA), Nitrous oxide					
INHALANTS Glue, Gasoline, Aerosols, Paint thinner, Poppers, Rush, Locker room					
OTHER Specify _____ _____					

Community and Long-Term Care Psychiatry, L.L.C.

10004 Kennerly Road Ste 362B
Saint Louis, MO 63128

Phone: 314-525-5050 Fax: 314-525-5072

AUTHORIZATION TO RELEASE INFORMATION

_____

Person(s) and/or organization

_____

Address

_____ _____

Phone Number Fax Number

Patient Name:_____

Date of Birth:_____

Social Security #:_____

I hereby authorize Community and Long-Term Care Psychiatry, L.L.C. to receive medical records, reports, labs or xrays pertaining to me and to release and/or receive full information regarding my condition including etiology, diagnosis or prognosis.

I also authorize Community and Long-Term Care Psychiatry, L.L.C. to receive any medical records, reports or any information pertaining to previous treatments of alcohol abuse and/or treatment of substance abuse, any psychiatric records or reports, and any information regarding treatment of AIDS or ARC. This authorization will remain valid for the course of treatment unless otherwise stated. A photographic copy of this authorization shall be valid as the original. It is understood that the person authorizing the release and/or receiving this specific information has the right to inspect and copy the information to be disclosed and that this information will not be re-disclosed without proper authorization.

_____ _____

Patient Signature/Legal Guardian Signature Date

COMMUNITY & LONG-TERM CARE PSYCHIATRY, L.L.C.
10004 KENNERLY RD, STE 362B, ST. LOUIS, MO 63125
Phone 314-525-5050 Fax 314-525-5072

Consent for Mental Health Evaluation and/or Treatment Version for Adults	**Name:** **Date of Birth:** **Record #:**

1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or course of treatment and chronic care management, as may be applicable, by staff from Community and Long-Term Care Psychiatry, LLC (hereinafter "Provider"). I have received complete and accurate information concerning each of the following areas:
    a. The benefits of the proposed evaluation, treatment, and/or chronic care management (as applicable):
    b. Alternative treatment modes and services
    c. The manner in which treatment/chronic care management will be administered
    d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable); and
    e. Probable consequences of not receiving treatment/chronic care management.

    The evaluation or treatment will be conducted by a psychotherapist, a psychologist, a psychiatric nurse practitioner, a psychiatrist, a licensed therapist or an individual supervised by any of the professionals listed. Treatment will be conducted within the boundaries of Missouri Law for Psychological, Psychiatric, Nursing, Social Work, Professional Counseling, or Marriage and Family Counseling. A chronic care management will be conducted by a physician or a psychiatric nurse practitioner in collaboration with a psychiatrist.

2. **Potential Benefits of Evaluation/Treatment/Chronic Care Management:** Evaluation and treatment may be administered by way of psychological interviews, psychological assessment or testing, psychotherapy, and/or medication management. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning so that appropriate recommendations and treatments may be offered. Uses of this evaluation or course of treatment may include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Chronic care management will be beneficial to me if I have two or more chronic conditions expected to last at least 12 months and this type of intervention may prevent exacerbation/decompensation of these conditions, or my overall functional decline. Possible benefits to treatment/chronic care management include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.

3. **Medical Insurance and Financial Responsibility:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles. I hereby authorize Provider or their designee to file a claim with my insurance company for the services rendered during the term of treatment and use the term "signature on file" as my signature. I authorize the medical insurance company to pay directly to Provider for the services rendered. I request payment of authorized Medicare benefits or Medigap benefits to be made on my behalf directly to the Provider, for any services that were furnished to me by the Provider or their designee. I authorize the holder of medical information about treatments and other services provided to me to release any information needed to determine these benefits to the health care financing administration, Medigap insurer, or their agents.

4. **Confidentiality, Harm, and Inquiry:** Information from my evaluation and/or treatment is contained in a confidential medical record at Provider's offices, and I consent to the disclosure of same for use by Provider staff for the purpose of continuity of my care. Information provided will be kept confidential with the following exceptions: 1) if I am deemed to present a danger to myself or others; 2) if concerns about possible abuse or neglect arise; or 3) if a court order is issued to obtain records.

5. **Right to Withdraw Consent:** This authorization will be perpetual unless I give written instructions to revoke it, which I may do at any time.

I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.

Signature of client	**Date**	**Signature of witness**	**Date**

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10004 Kennerly Road Ste 362B, Saint Louis, MO 63128 Phone: 314-525-5050 Fax: 314-525-5072

OFFICE POLICIES AND PROCEDURES

Thank you for choosing Community and Long-Term Care Psychiatry, L.L.C. as your provider for psychiatric services. We welcome you! We are committed to providing the finest personalized and professional care possible for our patients, and hope that the following information will help answer some of your questions and help you understand how our office operates.

Please note: If you are experiencing a psychiatric emergency, call 911 or go to the nearest emergency room for urgent treatment.

OUR BUSINESS HOURS AND SCHEDULING APPOINTMENTS:

Patients are seen by appointment only: walk-ins will not be seen. Our office is open Monday through Thursday from 8:00am to noon and 1:00pm to 5:00pm. On Fridays our office is open 8:00am to noon and 1:00pm to 3:00pm. Prescription refills, appointment scheduling and lab/test results should be handled during routine business hours. We will make every effort to schedule your appointment as soon as possible. Appointments may be scheduled by phone, in person or requested through the patient portal. At the time of your initial appointment is made, a non-refundable fee of $30.00 is charged. This fee is considered a partially prepaid co-payment (or a partial payment in the case of a private pay patient) and is applied to the patient's account at the time the initial appointment is made.

_____ initials

Late arrivals for scheduled appointments: We understand that delays can happen; however, we must try to keep the other patients and doctors on time. If a patient is 15 minutes past their scheduled time we will have to reschedule the appointment.

_____ initials

No call – no show fee policy: We realize that patients may need to change their appointments; however, we require a 24-hour notification of cancellation of your appointment so that we may offer that time to another patient. **If you fail to cancel your initial visit you will not be scheduled for another one and the partially prepaid co-payment will not be refunded to you. If you fail to cancel your follow-up appointment you will be billed for the scheduled time.** Our office charges $95 for a missed appointment. To avoid fees for broken appointments you must show up on time or call at least 24 hours prior to your scheduled appointment to cancel or reschedule. ***Note: These fees are a patient's responsibility, as insurance will not pay them.***

_____ initials

SCHEDULED APPOINTMENTS:

What to bring to your initial evaluation appointment: Your initial appointment will consist of a consultation to explain your diagnosis and treatment options. Please assist us by providing the following information at the time of your consultation, if applicable:

- A completed New Patient Forms Packet
- A list of prior treating physicians, psychiatrists, psychologists and therapists
- Information on any laboratory tests, procedures, or images completed in the past six months
- If you have medical insurance bring the cards issued by the insurance company
- A government-issued picture ID
- Your preferred method of payment
- You must bring all prescription bottles before any refill of **current medications** prescribed by a previous provider will be issued. Under no circumstances will our office refill medications without records being received directly from your previous doctor's office.

What to bring to your follow-up appointment:

- A list of any treating physicians, psychologists, or therapists that you started to get treatment from or were treated by since your last visit at our office
- Information on any laboratory tests, procedures, or images completed since your last visit at our office
- Your current insurance card
- Your current form of payment

Telemedicine Follow-up Appointment:

Before appointment

- Please make sure before your appointment to download doxy.me appt or to register with doxy.me online.
- Make sure to **test the doxy.me** platform before your appointment. If you are unable to get the equipment to work, it is your responsibility to get a hold of the office the day before your appointment to make sure that your equipment is functional and works with the system. If you are unable to be contacted through the system, not in the virtual waiting room, or for any other reason unable to get your system to work prior to your appointment, it will be considered a late cancel/no show and you will be responsible for any applicable fees.
- Please make sure to send in your telemedicine follow-up questionnaire and any screening tools applicable to your individual care and conditions 24 hours prior to your appointment. If this paperwork is not received, your appointment will need to be rescheduled and considered a late, cancel, or a no show and you will be responsible for applicable fees.
- Please make sure to email any information on any laboratory tests, procedures or images completed since your last visit.
- Please make sure the staff has your updated insurance card 48 hours prior to your appointment. *It may be wise to attach a copy of the front and back of your insurance card(s) to your follow-up telemedicine paperwork.*
- Please make sure your medication list is current in your patient portal.

SUPPLEMENTAL CONSENTS:

This consent to treatment represents my consent to medical and psychiatric treatment provided to me or my child/ward by Community and Long-Term Care Psychiatry, L.L.C. (CLTCP), and all healthcare professionals working in collaboration with the practice. I voluntarily authorize the examinations, tests and procedures customarily performed on patients with my condition and consent to customary treatments as ordered by the providers, including medication treatment. I also consent to drug testing if deemed appropriate by my practitioner.

_____ initials

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made by any of CLTCP providers, employees, or affiliates, to the results of treatments or examinations.

_____ initials

I understand that medications may be prescribed by a CLTCP provider for the treatment of my or my ward's condition. I recognize that I have the right at any time to ask more questions regarding the treatment. I recognize that it is my responsibility to clarify any treatment decisions my provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I accept and take a medication, I am responsible for understanding risks vs benefits of those medications and if I take a medication I am consenting to treatment as well as potential interactions with other treatments. If I accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label medication means I am consenting to all the risks associated with taking a medication not labeled or studied for my condition.

_____ initials

I understand that vitamins may be offered by CLTCP provider for the treatment of my or my ward's condition. I understand that supplements are frequently not regulated by the FDA. I understand that frequently supplements may interact with medications in a way that is not fully understood. I also recognize that it is my responsibility to clarify any treatment decisions the provider has recommended. I also recognize that if I have further concerns, it is my responsibility as a patient or patient's representative to voice those concerns. I also agree that if I agree for a treatment with a vitamin/supplement, I am responsible for understanding risks vs benefits of those supplements and if I, or my ward, take a vitamin/supplement, I am consenting to treatment and accept all risks of treatment as well as potential interactions with other treatments. If I accept off-label treatment, I acknowledge that I have the right to ask for alternative treatments that are not off-label and I understand that taking an off-label vitamin/supplement means I am consenting to all the risks associated with taking a medication not labeled or studied for my condition.

_____ initials

I understand that treatment compliance is extremely important. I understand that by not making follow-up appointments, not taking prescribed medications regularly, or not discussing with treating practitioner the personal decisions I make regarding the way I am taking my medications, could result in adverse effects to my health up to and including death. I recognize it is my responsibility to notify the provider of any concerns or

health up to and including death. I recognize it is my responsibility to notify the provider of any concerns or changes I believe are necessary for my, or my ward's, treatment plan. It is also my responsibility to make sure the provider knows what changes have been made by other treatment providers. I recognize that it is my responsibility to document my concerns or health changes and address them with my practitioner.

_____ initials

I have read or have had read to me this consent and understand and agree to its contents. I understand that the consent for medical treatment, authorization for release of information and assignment of financial responsibility will be valid for the duration of treatment and can only be revoked upon written notice. By initialing below I acknowledge that this consent form has been read in full and explained, as necessary.

_____ initials

MEDICATION MANAGEMENT:

Medication Refill Policy: You must notify us **during your visit** of any and all prescription refills needed before your next visit. Medications will be prescribed at the time of appointment, and you will always be given enough medication and refills until the next office visit, so refills are not necessary over the phone. This is to limit medication errors and to protect your safety. If you have missed or cancelled and appointment, you will need to schedule another visit and will be provided with enough medication until the re-scheduled visit.

_____ initials

Refill of controlled substances: Prescriptions for controlled substances (stimulants or benzodiazepines) **<u>will not be reissued</u>** until 3 (three) calendar days before the date the prescription is due to run out. You are responsible for safeguarding your prescriptions and medications.

NOTE REGARDING OUR BENZODIAZEPINES PRESCRIBING STRATEGIES: We care about your overall safety, health and longevity. We expect all patients to be willing to gradually wean themselves off benzodiazepines over time and to acquire other healthier coping mechanisms.

_____ initials

PAYMENTS AND INSURANCE:

Payment Policy: Payment in full of all applicable charges is due when the service is rendered. If you are unable to provide the payment of all applicable fees, your appointment will be rescheduled. For your convenience, our office accepts all major credit cards, cash or personal checks. We do not accept post-dated checks. There is a $50 fee for checks returned for insufficient funds. **Patients with balances over $150 must either pay the balance or make payment arrangements prior to your future appointments being made.**

_____ initials

Insurance: Our company is an "in network" provider for most major insurance carriers and for Medicare. Before you come in for an appointment, please check with your insurance carrier regarding the amount of

co-payment that you will be charged for our service. As a courtesy to our patients, we will file insurance claims for those insurances with which we participate. If the patient fails to provide us with the correct information, they are financially responsible for the office visit charges. **Please remember, any amount not covered by insurance is ultimately the patient's responsibility.** The required co-payment cannot be waived, as doing so may violate our contract with your insurance carrier. We accept "out of network" benefits from most out-of-state insurance plans. Our office no longer accepts Medicaid patients.

_____ initials

TELEPHONE POLICY:

We take pride in answering your call in person whenever possible however, there are times when heavy call volume may prevent us form speaking with you directly.

If you get a recording, **it is important that you follow these instructions:**

- Please do NOT call more than once a day for the same issue.
- Please keep your message as brief as possible (name, number and reason for call). For example; "Jane Doe, 555-1212, I need to reschedule my appointment."
- Please allow up to 24 **business** hours for a return call, especially if you call late in the day.
- Medical issues will not be addressed over the phone. Please make an appointment.
- Office staff will be polite and respectful to you and deserve the same in return.
- Calls may be recorded for quality control purposes.
- Abusive or incessant calls are cause for termination from our practice. All threats are reported to the proper authorities.

Call In Policy: To uphold the quality of care and in fairness to all of our practice patients, our providers cannot take time out of their scheduled appointments to accepts or return patient phone calls. If you feel you must speak with your provider, please make an appointment to allow them to give you the care and attention you deserve.

FMLA/LEGAL/OTHER MEDICAL PAPERWORK HANDLING AND CHARGES:

Routine school or work excuses are available upon request at the end of your appointment. If time permits, brief forms (less than 5 minutes) may be completed during your allotted appointment time and there will be no additional charge. Longer forms and letters will be done outside of appointment time and the fee will be based on the time involved to complete the service. Please see below.

Simple (less than 5 minutes) No Charge

Moderate (5-15 minutes) $50.00

Lengthy (15-30 minutes) $100.00

Complex (over 30 minutes) $200.00/hour

Upon written request, records will be copied. It typically takes a week to have copies made. Copies of charts will be mailed or faxed directly to the requesting entity. The fee for copying is:

$27.13 preparation/handling fee
$0.62 for each copied page

Payment of $50.00 for the copied documents must accompany the written request. Refund of overpayment will be placed into the patient's account. Any additional charge (for over than 20-page file) will be billed separately.

Mental health records are standard practice in psychiatry. They are protected by both law and professional standards. While you are entitled to review a copy of your record, they can occasionally be misinterpreted given their professional nature. In rare instances, when it may be deemed potentially damaging for our clinicians to provide you will the full records, we can ensure that they are made available to an appropriate mental health professional of your choosing. They will need to provide us with a written record request accompanied by the Release of Information form personally signed and dated by your or your guardian. Please note that professional fees will not be charged for any preparation time required to comply with such requests.

_____ initials

TERMINATION POLICY:

It is the policy of this practice to establish and maintain a cooperative trust-based provider/patient relationship. Should the relationship, trust or mutual goals of the provider and patient not be realized, either party may terminate the relationship within the bounds of applicable state and federal laws, rules and regulations.

_____ initials

PRIVACY POLICY:

Use of recording devices in the office is prohibited unless approved in advance in writing. Violators are subject to termination. The form, Notice of Privacy Practices, presents the information federal law requires us to give our patients regarding our privacy practices.

_____ initials

CONFIDENTIALITY:

Confidentiality is a cornerstone of mental health treatment and is protected by law. Aside from emergency situations, information regarding your care and treatment can only be released with your written permission. If you are seeking insurance reimbursement, insurance companies also often require information about diagnosis, treatment and other important information as a condition of your insurance coverage. They may occasionally request some of your medical files as you have given them permission to access this information when you signed an insurance contract with them.

There are legal exceptions to confidentiality that may require us to disclose the information about you:

(1) Danger to yourself – if there is an explicit threat to harm yourself, our staff is required to seek hospitalization for the patient, or to contact family members or others who can help us provide your protection or aid in your hospital if necessary

(2) Danger to others – if there is threat by you of serious bodily harm to others, our staff is required to take protective actions, which may include notifying the potential victim, notifying the police, or any other appropriate authorities

Grave disability- if, due to a mental illness, you are unable to meet your basic needs, such as clothing, food and shelter, our staff may have to disclose information to your family members or the proper agencies in order to help you access to help meet those basic needs

(3) Suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disable person – even if it is about a party other than yourself – our staff must file a report with the appropriate state agency

(4) Certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a subpoena

Although these situations can be rare, our staff will make every effort to discuss the proceedings accordingly. We reserve the right to consult with other professionals or with our legal department when appropriate. In these circumstances, *your identity will not be revealed*, and only important clinical information will be discussed. Please note that such consultants *are also legally bound to keep this information confidential.*

_____ initials

I have reviewed and understood the information above.

_____ _____

Signature of Patient/Guardian Date

_____

Printed Name

Community and Long-Term Care Psychiatry, L.L.C

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of privacy practices describes how we may disclose you protected health information (PHI) to carry out treatment, payment or healthcare operations and for that purpose that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition 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 our office that are involved in your care and treatment for providing health care services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your 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 physician to whom you have been referred to ensure that the physician has the necessary information for your treatment, care and diagnosis.

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 would be disclosed to your health plan to obtain approval for a hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, training of medical students, licensing, and conducting or arranging other business activities. For example, we may disclose protected health information in the recruitment and/ or conduction of clinical research studies in which you qualify as a subject and subsequently benefit thereof. 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 in the following situations without your authorization. Those situations include: As required by law, public health issues 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; Worker's 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 made only with your consent, authorization, or opportunity to object unless required by law. You may revoke this authorization at any time, in writing except to the extent that your physician's practice has taken an action in the reliance on the use or disclosure indicated in the authorization.

You have the right to inspect and copy your protected health information. Under federal law however you may not copy or inspect the following records: psychotherapy notes, information compiled in a reasonable anticipation of, or use in a civil, criminal, or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information. You have the right to request a restriction of your protected health information. Your physician is not required to agree to a medical records restriction request. If the physician believes it's in your best interest to permit use and disclose your protected health information, your protected health information will not be restricted. You have the right to obtain a paper copy of this notice from the practice. We reserve the right to change the terms of this notice and will inform you.

Signature below is only acknowledgment that you have received this notice of our Privacy Practices

_____

Printed Name

_____ _____

Signature Date