Valley Integrative Psychiatric Health & Wellness

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New Patient Packet

Welcome to VIP Health & Wellness! We are excited to assist you on your way to wellness.

*The goal of VIPHW is to help patients achieve their highest level of*

*physical, and emotional wellness through collaborative*

*mental health solution*

**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.

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

**Emergency Policy**

*VIPHW* 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

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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 to 48 hours.

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.

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Patient/Guardian Signature Date

**Patient Discharge**

Patients will be discharged for 3 no show appointments.

*VIPHW* 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

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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 $50.00 per missed appointment without at least 24 hours notice.

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

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

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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 Valley Integrative Psychiatric Health & Wellness 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

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgeries: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Medical Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Non-prescription Medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Prescription Psych Medications (Please include medication, dosage and times taken per day):\_\_\_\_\_\_\_\_\_

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Prescription Non- Psych Medications (Please include medication, dosage and times taken per day):\_\_\_\_\_\_\_\_\_

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# FORM OF ACKNOWLEDGEMENT

**Valley Integrative Psychiatric Health & Wellness**

**RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I acknowledge that I was offered a copy of the Valley Integrative Psychiatric Health & Wellness Notice of Privacy Practices effective January 1, 2018.

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

**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 agreements 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 hours 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

# AUTHORIZATION FORM

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

1. **Authorization for Release.**  The undersigned hereby authorizes Collaborative Psych Practitioners and its employees to use and/or disclose 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)

1. **Authorization to Release/Transfer.**  The undersigned hereby authorizes to release the following health information to Collaborative Psych Practitioners and its employees for the purpose of continuation of my medical/surgical care:

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)

1. **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.
2. **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.
3. **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.
4. **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:

Valley Integrative Psychiatric Health & Wellness

ATTN: Anise Tatiana Wheeler

1822 W Kettleman Lane, Suite 1

Lodi, CA 95242

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 ACCOUNT NUMBER (IF KNOWN)

SIGNATURE OF PATIENT OR GUARDIAN DATE

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