Midlothian
Behavioral Health Associates
TMS Center of Richmond

Thank you for choosing Midlothian Behavioral Health Associates, LLC.
In order to serve you better we require the following information.
All information is considered confidential. **Please Print.**

Name: _____ **DOB:** _____ **Gender:** ___Male ___Female

Preferred Name: _____ **SSN:** _____ **Marital Status:** __Single __Married __Divorced __Widowed

Address: _____**City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____**)** _____ **Cell Phone: (**_____**)** _____ **Work Phone: (**_____**)** _____ **Ext.**_____

Email: _____ **Referred By:** _____

INSURANCE INFORMATION (Primary)

Insurance Company Name: _____

ID: _____Group#:_____ Effective /Issue Date: _____

Guarantor Name: _____ DOB: _____ Phone: _____ Relationship to Insured: _____

INSURANCE INFORMATION (Secondary)

Insurance Company Name: _____

ID: _____Group#:_____ Effective /Issue Date: _____

Guarantor Name: _____ DOB: _____ Phone: _____ Relationship to Insured: _____

Pharmacy: _____ **Address:** _____ **Phone:** _____

EMERGENCY CONTACT

Emergency Contact: _____ **Phone: (**_____**)** _____ **Relationship:** _____

Address: _____**City:** _____ **State:** _____ **Zip:** _____

I give MBHA permission to discuss the following with the individual above: (check all that apply)

☐ **Appointments** ☐ **Billing** ☐ **Treatment/Medication**

Patient/Guardian Signature: _____ **Date**: _____

AUTHORIZATION FOR CLAIMS, PAYMENT AND REVIEWS

Please understand that payment of your bill is considered a part of your treatment.
The following is a notice of how our claims, payment and policies are upheld. Please read and sign this page prior to treatment.

Full payment for professional services is due at the time of services.

As a courtesy, we will try to contact your carrier to confirm coverage and estimate their payment for services rendered. **It is ultimately the responsibility of the patient to know what type of treatments and services are covered under their individual insurance plan. We require you to make your payment at time of services**

NOTICE TO TRICARE BENEFICIARIES

If you are a TRICARE beneficiary, the prior paragraphs do not apply to you. When you visit one of our physicians or physician's assistants, please identify yourself as a TRICARE beneficiary. If the services to be rendered to you are excluded from your TRICARE benefits, your payment option for these excluded services will be discussed with you at the time of your visit. If the services to be rendered to you are covered as a TRICARE benefits, your only charge will be the applicable deductible, copayment and/or cost-sharing amount.

Please be aware that very few insurance companies attempt to cover all medical costs. Some companies pay fixed allowances for each procedure/service while others pay only a percentage of the cost. Our practice is committed to providing the best treatment to you, and we charge what is usual and customary for this area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates which may bear no relationship to the current standard and cost of care in this area.

As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. You will need to present a completed referral at the time of your appointment. As required by insurance mandates you are also responsible to obtain the appropriate authorization for medical treatment. In the event that you are seen (by your acknowledgement) without the proper referral/authorization as required by your insurance carrier, you will be responsible for payment of all fees at the time of service. We will file your claim with your insurance carrier and reimburse you if they issue a payment to us. We ask that you participate in any dispute with your insurance carrier regarding your policy guidelines and regulations.

Please Initial Terms below:

I, authorize release of information, including financial information and confidential health information and medical records for services rendered regarding my condition, which may include records related to treatment for substance abuse to my insurance carrier(s), managed care plan or other party, past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law. **(Initial)_____**

In my capacity as a patient, legal representative or representative payee for the patient, I agree to pay all the charges for which I may be legally responsible including but not limited to health insurance deductibles, co-payments, and non-covered services. In the event my account must be placed with an attorney or collection agency to obtain payment, I agree to pay reasonable attorney's fees and other collection costs. **(Initial)_____**

By signing below I certify that I have read and understand the Authorization for Claims, Payments, and Reviews, have had the opportunity to ask questions and have them answered and accept the above condition and terms. I further certify that I am the patient or guardian, duly authorized representative, parent or other family member of the patient.

_____**Date**_____

Patient Name (please print)

_____ _____

Signature (Patient or Responsible Party) Relationship to patient (Guardian/Parent)

Office Policies

- **Primary Care Referrals:** Please obtain all of the necessary referral forms (if required by your insurance) from your primary care physician in advance of your visit. Unfortunately, patients cannot be seen without the appropriate referral.

- **Co-Payments/Balance:** Co-payments and deductibles must be paid upon the patient's arrival. Any patient with a balance **over 60 days <u>will have to pay in full or reschedule</u> their appointment**. We accept cash, Discover, Visa, and MasterCard.

- **Non-covered Services:** Must be paid for at the time of service.

- **Tardiness:** Please call if you running late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we will try to deliver the same respect for your time if we are running late the session will be completed in its entirety.

- **Cancellations:** We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other patients that could benefit from this treatment slot. Patients that do not contact the office within the 24 hour period to cancel their appointment will be charged a $50 fee for the missed appointment.

- **Repeat Missed Appointments:** We will be unable to schedule future appointments for patients having ***three (3) missed appointments and/or cancellations without appropriate notice,*** particularly if we feel that these missed appointments are adversely affecting the treatment plan. ***Please be advised that failure to receive an e-mail or phone call reminder does not absolve you from keeping track of your own appointment.***

- **Medication Refills:** To ensure that your medication needs are met in a timely manner, we request that you notify us at ***least three (3) days prior to the date your medication is scheduled to run out***. There ***will be a 15.00 fee assessed*** when a prescription is obtained prior to a scheduled appointment without sufficient three day notice.

- **Returned Checks**: Will be processed with a service charge of $40. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. In addition, patients whose accounts have been referred to collection agencies must pay any outstanding balance and pay for each visit in full at the time of the appointment before additional services/care will be provided.

- **Paperwork Charge:** $50 charge for paperwork, reports, etc. Requests exceeding (2) pages may incur additional fees. These paper work requests will take up to the allowed (10) business days from the date we receive written request. A charge of $5.00 will be applied for medical records requested by the patient, record requests can take up to 30 days. Patients requesting records must be present to pick-up requested records and sign a release in receipt of their records. We do not email records, we are happy to fax or mail records as per your request.

- **Subpoena for Witness:** If any of the providers are subpoenaed for court, the fee is $250/hr. for a minimum of 4 hours. This fee includes preparation time, travel, waiting, testifying, etc. Additional fees may be assessed if travel out of the immediate area is required. Payment in full is required 7 business days in advance of the scheduled hearing. This fee continues to apply even if the provider does not testify. Additionally, fees will remain in effect in the event that court is canceled, continued, or rescheduled less than 3 business days prior to the court appearance for any reason. (e.g. weather, the judge cancelling the day, settlement of the case outside of court, etc.).

X._____ _____

Signature of Patient or Responsible Party Date

Informed Consent for Treatment and Release of Information

I voluntarily consent to care and treatment by Midlothian Behavioral Health Associates, LLC. I am aware that I am an active participant in this endeavor, and that I share the responsibility for treatment by providing all accurate information about my history. I understand that our work will be kept confidential with the exception of legal limitations on confidentiality. I am aware that, although my provider is a clinically independent practitioner, consultations with associates are at times clinically advisable and my signature below gives them permission to do that. The associates also provide emergency coverage for each other when one is out of town, and I understand that an associate providing coverage for my provider may need access to relevant information to provide the best interim care possible. I have the right to revoke this consent in writing and terminate services at any time.

PRIMARY CARE PHYSICIANS

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. **Please make a selection below**.

☐ I give consent for information regarding my treatment to be shared with my PCP/Referring Physician/Therapist as follows:

Name of PCP/Referring Physician: _____ Phone:_____

Located at: _____

Name of Therapist: _____ Phone:_____

Located at: _____

☐ I **do not** wish to have information regarding my treatment with this practice released to my PCP/Referring Physician/Therapist.

REALITIVES, FRIENDS AND OTHER CAREGIVERS

I agree that the practice may disclose certain health information to a personal representative of my choosing, since such person is involved with my health care or payment relating to my health care. MBHA will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

Name: _____ Relationship: _____ Phone:_____

COMMUNICATION

I hereby understand that my filling out contact information below allows this group to share information with you via voice mail or email. Please check all that apply. ***Please be advised that failure to receive an e-mail or phone call reminder does not absolve you from keeping track of your own appointment.***

__Home Phone __Cell Phone __Work Phone __Email

X _____

Printed Name

X_____ **Date: _____**

Patient Signature (or parent/guardian)

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§164.520(a))

I,_____, (patient's name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information. I understand that: I have the right to review this facility's Notice of Privacy Practices prior to signing this acknowledgement; This facility reserves the right to change their Notice of Privacy Practices and prior to implementation of this will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Guardian: _____ Date: _____

Printed Name of Individual or Guardian: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

_____ Individual refused to sign
_____ Communication barrier prohibited obtaining the acknowledgement.
_____ Emergency situation prevented us from obtaining acknowledgement.
_____ Other (please specify)
_____

Office Staff Signature_____**Date**:_____

Midlothian Behavioral Health Associates, LLC

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