Consent Form for the Following:

Mental Health Evaluation, Mental Health Treatment AND/OR Medication Management

1. <u>Consent to Evaluate/Treat</u>: I voluntarily consent that I will participate in a mental health (e.g, psychological or psychiatric) evaluation and treatment, as necessary, by staff from Cedar Valley
Psychiatry, LLC. I understand that following the evaluation, complete, accurate and educational information will be provided concerning each of the following areas:

a. My Diagnosis.
b. My Prognosis.
c. The proposed treatment, including the benefits of the proposed treatment.
d. The manner in which treatment will be administered.
e. Expected side effects from the treatment and/or the risks of side effects from medication(s) (when applicable).
f. Probable consequences of not receiving treatment.
g. Alternative treatment modes and services.

The evaluation and treatment will be conducted by a psychiatrist, social worker, or therapist. Evaluation and treatment will be conducted in accordance with applicable state and federal laws. Communication and coordination of care will be done regularly between the psychiatrist and other treating providers/team members from Cedar Valley Psychiatry.

2. <u>Medication(s) Consent</u>: I am the patient and/or legal guardian and I consent to the administration of this psychiatric medication if needed. I have been educated regarding the possible side effects of medication(s) (when applicable), possible drug and/or food interactions that may occur while taking this medication and the possible effects of this medication(s) if the person taking this medication(s) becomes pregnant. I have also been informed of the reason or purpose for which this medication(s) was prescribed.

a. It is recommended that women who are or may become pregnant, or are breast-feeding discuss this with their doctor **<u>before</u>** taking **<u>any</u>** medication.

b. It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, which side effects to report **<u>immediately</u>** to a health care provider.

3. <u>Benefits to Evaluation/Treatment</u>: Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic performance, health status, quality of life, and awareness of strengths and limitations.

4. <u>Charges</u>: 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. Fees are available to me upon request.

5. <u>Right to Withdraw Consent</u>: I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician.

By signing this form, I indicate that I have read and understand the above, have had an opportunity to ask questions about this information, and consent to the evaluation and treatment.

I also attest that **I** have the right to consent for evaluation and treatment. **I** understand that **I** have the right to ask Cedar Valley Psychiatry, LLC questions about the above information at any time.

______________________________________ ____________

Signature of patient ages 14 years or older **Date**

______________________________________ ____________

Signature of Legal Guardian **Date**

Cedar Valley Psychiatry
8130 Adams Drive, Hummelstown PA, 17036
Phone (717) 967-8288 Fax (717) 967-8291

Patient Demographics

Date: ___________

Last Name: ___________________________ **First:** _________________________ **Middle Initial:** ____

Circle One: MALE or FEMALE

Address: ____

City: ________________________ **State:** _____ **Zip:** __________

Home Phone: (_______) _______-_________ **Voicemail (circle one)** YES NO

Work Phone: (_______) _______-_________ **Voicemail (circle one)** YES NO

Cell Phone: (_______) _______-___________ **Voicemail (circle one)** YES NO

Email: ____

DOB: ______/______/______ **Age**: _____

Marital Status: _________________________

Employer: __________________________ **Occupation:** __________________________________

College/School (if currently enrolled): ____

Pharmacy Information:

Pharmacy Name:__________________________________ **Number:**_____________________________

Emergency Information

Emergency Contact Name: ________________________________

Phone: ______________________________

Relation to Patient: ____

Do you have a Mental Health Directive or Mental Health Power of Attorney assigned to make mental health decisions for you if you become incapacitated? YES NO

Reason for Visit (optional)

____

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FINANCIAL AGREEMENT

PATIENT NAME____ **DOB** ______/______/____________

I understand that all professional services rendered will be charged to the above patient. I agree that I am financially responsible for those services. **I understand that although Cedar Valley Psychiatry may assist in processing my claims, it is my responsibility to assure that any insurance coverage I have, is current, and will reimburse for services provided. In addition, I will be responsible for any amount not covered by my insurance.**

I authorize Cedar Valley Psychiatry to bill my insurance company and provide them with any medical or other information necessary to process claims for reimbursement for services and service dates. I also request payment of insurance to be made directly to Cedar Valley Psychiatry.

I authorize Cedar Valley Psychiatry to provide any health information (medical/psychiatric/psychotherapy notes) to my health insurance providers in case of an audit or financial review of my health record (coding/diagnoses/services/billing) requested by them.

SIGNATURE ____ DATE ______________

PRINTED NAME ____

Office Payment Policy (For all patients to read and initial each paragraph)

I understand that payment is expected at the time of service, unless other arrangements have been made in advance. All copayments, regular coinsurance payments and deductibles will be collected at the time of service by check, cash, and all major credit cards or debit cards. **(Initial here) ________**

I understand that I will be charged for any appointment that I schedule and do not keep, unless I cancel that appointment at least 2 (TWO) BUSINESS DAYS prior to that scheduled appointment. The charge for a missed appointment will be a service fee of $30.00

(Initial here) ________

If the patient does not follow the recommended treatment plan, which may include, scheduling and keeping appointments, following doctor and therapist recommendations, and making payments, the clinician may need to discharge the patient. (This may include, but is not limited to the patient not showing for 2 or more sessions, or canceling 2 consecutive sessions, but is at the discretion of the clinician.)

(Initial here) ________

All medical record requests for patients will be processed with a signed release of information from Cedar Valley. A flat fee of $20 will be charged for medical record request. (In the event that any record is more than 25 pages subsequent fees will be assessed.) Records will not be released until payment is made. **(Initial here) ________**

I understand that a return check fee of $20.00 will be charged for any returned checks. **(Initial here)** _______

Cedar Valley reserves the right to access credit data for the purposes of granting credit and/ or collections of any account. I will be responsible for any attorney or collection fees incurred in the collection of any balance owed. **(Initial here) ______**

PRIVATE PAY (please complete only if we do not accept your insurance)
I understand that Cedar Valley Psychiatry does not accept my health insurance at this time. Service Fees will be due in full at the time of visit. I agree I will be paying for services out of pocket at the time services are rendered.

SIGNATURE____DATE ____________________________________

By signing here, I agree that I have read and will abide by Cedar Valley's financial policy in its entirety. I have had the opportunity to ask questions and discuss any concerns.

SIGNATURE ____ DATE ____/____/____

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8130 Adams Drive, Hummelstown, PA 17036
Tel: 717-967-8288, 717-545-1427, Fax# 717-967-8291

ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES

I, the undersigned have received a copy of the Notice of Privacy Practices of Cedar Valley Psychiatry, LLC. If the patient is less than fourteen years old, then a Parent/ Guardian must sign the Acknowledgment on behalf of the patient.

______________________________ ______________________________
Patient Name **Patient Signature**

______________________________ ______________________________
Parent/ Guardian Name Parent/Guardian Signature

____
Date

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barriers prohibited obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)
  ____

<u>This form does not constitute legal advice</u>

CEDAR VALLEY PSYCHIATRY, LLC

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

For yourself and emergency contact/anyone you would like us to release your medical info to.

Patient Name: ____ **Date of Birth:** _____ /_____ /__________

1. I authorize the use or disclosure of the above-named individual's health information described below

2. The following individual(s) or organization(s) is/are authorized to make this disclosure:

CEDAR VALLEY PSYCHIATRY, LLC
8130 Adams Drive, Hummelstown PA, 17036 **Phone:** 717-967-8288 **Fax:** 717-967-8291

3. The information identified below may be disclosed to or used by the following individual(s) or organization(s):

Self

Name: ____

Address: ____

Phone: ____________________ **Fax**: ______________________

4. The type of information that may be disclosed is as follows:

☐ Diagnostic and medical history ☐ Entire record ☐ Summary Only

☐ Other (Please, give specific description) ____

5. Specially protected information (Please, check all that apply)

☐ I understand that the information to be disclosed may include information relating to AIDS or HIV

☑ I understand that the information to be disclosed includes mental health information:

☑ With psychotherapy notes ☐ without psychotherapy notes

☐ I understand that the information to be disclosed may include information about treatment for drugs, alcohol or substance abuse.

6. This information for which I am requesting disclosure will be used for the following purpose:

☑ My medical treatment ☑ Insurance payment/reimbursement ☑ my personal use

☐ To evaluate my eligibility for life insurance coverage

☐ To evaluate my eligibility for disability benefits ☐ at the request of my attorney:

Name: ________________________________ **Address:** ________________________________

Other: (Please, describe) ____

7. I understand that I have the following rights:

7.1 Right not to sign. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Cedar Valley Psychiatry LLC except when health services are solely for the purpose of reporting to a third party.

7.2 Right to revoke. You may revoke this authorization at any time. Your revocation will not apply any release made in response to this authorization: To revoke this authorization, you must submit a written revocation to:

Dr. Gale Georgeff
Cedar Valley Psychiatry
8130 Adams Drive, Hummelstown PA, 17036

7.3 Re-disclosure. I understand that once the information listed above has been disclosed, it could potentially be re-disclosed because the information may no longer be protected by federal privacy laws or regulations.

8. Expiration date of event: ____________

I have read and understand this authorization, and authorize the use and/or disclose of the health information as described in this authorization.

Patient signature: (14 year old, parent, legal guardian or other legally-authorized representative)

____ **Date:**_____ /_____ / __________

Name of personal representative if signed above: (please, print): ______________________________________

Relationship to patient: ____

CEDAR VALLEY PSYCHIATRY, LLC

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8130 Adams Drive, Hummelstown PA, 17036 **Phone:** 717-967-8288 **Fax:** 717-967-8291

3. The information identified below may be disclosed to or used by the following individual(s) or organization(s):

Weight loss Clinic

Name: ____

Address: ____

Phone: ______________________ **Fax**: ________________________

4. The type of information that may be disclosed is as follows:

- ☐ Diagnostic and medical history ☐ Entire record ☐ Summary Only
- ☐ Other (Please, give specific description) ____

5. Specially protected information (Please, check all that apply)

- ☐ I understand that the information to be disclosed may include information relating to AIDS or HIV
- ☑ I understand that the information to be disclosed includes mental health information:
  - ☑ With psychotherapy notes ☐ without psychotherapy notes
- ☐ I understand that the information to be disclosed may include information about treatment for drugs, alcohol or substance abuse.

6. This information for which I am requesting disclosure will be used for the following purpose:

- ☑ My medical treatment ☑ Insurance payment/reimbursement ☑ my personal use
- ☐ To evaluate my eligibility for life insurance coverage
- ☐ To evaluate my eligibility for disability benefits ☐ at the request of my attorney:

Name: ___________________________________ **Address:** __________________________________

Other: (Please, describe) ____

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____ **Date:**_____ /_____ / __________

Name of personal representative if signed above: (please, print): ____________________________________

Relationship to patient: ____

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8130 Adams Drive, Hummelstown PA, 17036
Phone: 717-967-8288   Fax: 717-967-8291

Payment Policy
Thank you for choosing us as your primary psychiatric provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in several insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

4. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with 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 your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. If your account is over 30 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Please be aware that if a balance remains unpaid you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

8. Missed appointments. Our policy is to charge for missed and cancelled appointments that are not within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to 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 for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.