New South Psychiatry, P.C.

3209 Midtown Park S, Mobile AL, 36606

Office: 251-525-9090 / Fax: 251-525-9091

www.newsouthpsychiatry.com

Client Rights

- The right to be treated with dignity and respect by all staff.
- The right to be involved in the planning of my treatment plan.
- The right to know about my treatment plan.
- The right to a clean and safe environment.
- The right to refuse to be videotaped, audio recorded, or photographed.
- The right end treatment at any time unless court ordered.
- The right to file a complaint or grievance about the agency or staff.
- The right to confidentiality of clinical records and PHI according to Federal and State laws.

Limits of Confidentiality

I understand that the process and contents of intake, assessments, and/or counseling are protected under the Federal and State laws. Other verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information.

Noted exceptions are as follows:

- Signed authorization to release information to a specific individual or organization.
- Clinician's determination that you may harm yourself or someone else.
- Disclosure of abuse, neglect, or exploitation of a child, the elderly, or disabled.
- Disclosure of professional misconduct of another mental health professional.
- Court order or requirement by law to disclose information.
- Prenatal exposure to controlled substances.
- In the event of a client's death (The spouse or parents of a deceased client have a right to access their spouses or child's records).
- Minors/Guardianship.
- Insurance Companies.

By signing this document, I agree with the following statement: I understand my right to confidentiality and the above noted exceptions.

Client Name (printed) : _____

Client Signature: _____ Date: _____/_____/_____

Consent for Services

Please review the policies of New South Psychiatry, P.C. and initial each field to indicate that you have understood and consented to the following guidelines.

Informed Consent for Treatment: I give consent for myself or my legal dependent to be treated at New South Psychiatry, P.C. I understand the I (patient/client) must be committed to attend my appointments on a consistent basis to receive the best benefit from my clinical treatment. I understand that I may at any time decline specific treatment recommendations. If my provider believes that I can receive more effective treatment elsewhere, I will be given referrals. I understand that I may not attend a session if I am under the influence of alcohol or drugs, or if I am in possession of a dangerous weapon.

After Hours Call: I acknowledge and understand that New South Psychiatry, P.C. does not have a 24 hour on-call Physician/Clinician available and that in the event in which I (the patient/client) experience an emergency I will call 911 and/or got to nearest emergency room.

Practice Hours: I acknowledge that clinical hours are Monday through Friday from 8:15 AM to 5:00 PM.

Insurance Reimbursement:

I understand that New South Psychiatry, P.C. will directly bill my insurance company, following my appointment.

Pregnancy:

I agree to disclose any possible pregnancy to my physician and agree to making medication adjustments for safety based upon the physician's suggestion and educational training.

Communications:

I give consent for New South psychiatry, P.C. to contact my home or alternative location via phone and leave a voicemail message in reference to appointment reminders, insurance items, and clinical care.

I give consent for New South Psychiatry, P.C. to correspond with me via mail addressed to my home in reference to clinical care or financial statements.

I agree to provide New South Psychiatry, P.C. with any changes to information regarding names, addresses, payment information, and insurance information.

I understand that all communications with New South Psychiatry, P.C. will be documented in my chart.

Closures and Holiday's:

New South Psychiatry, P.C. will be closed on Fat Tuesday, Fourth of July, Thanksgiving, Christmas Day, and New Year's Day. Please plan and coordinate with staff for these closures.

Cancellations and Appointment Policy:

I understand New South Psychiatry, P.C. requires a 24-hour cancellation notice. Failure to comply with this policy will result in a same-day cancellation or No-Show fee of $100.00. New South Psychiatry, P.C. will call one business day prior to scheduled appointments to issue patient reminders.

I understand that after the third no-show to my scheduled appointment I will be released from care of this practice and provided a referral.

I agree to provide New South Psychiatry, P.C. debit or credit card information.

I understand and agree that same-day cancellations and no-show appointment fees will be charged to the debit or credit card information that I provided, and I authorize such transactions.

Credit Card Authorization Agreement:

I hereby authorize New South Psychiatry, P.C. to charge the following payment information to pay for services rendered for my treatment. I also authorize New South Psychiatry, P.C. to charge same-day and cancellation fees to the payment information provided below.

I certify that I am an authorized user of the payment information and will not dispute the transaction.

I authorize New South Psychiatry, P.C. to disclose any attendance/cancellation information if a dispute takes place.

Credit Card Type:

- ❑ MasterCard
- ❑ Visa
- ❑ American Express
- ❑ Discover Card

Card Number: _____

Cardholder Name: _____

Expiration Month: _____ Expiration Year: _____ Security Code: _____

Signature: _____ Date: _____

I understand that any verbal changes to this information will be documented within my patient chart.

Patient Controlled Substances Agreement:

Please initial each line to acknowledge that you understand and agree with the policies for controlled substances.

_____ Initial evaluations are to establish care and create a treatment plan, **we do not** prescribe controlled substances on initial appointments. Care must be established for a minimum of 2 months before physicians will consider treatment with the use of controlled substances.

_____ I agree to random urine drug screenings and understand that any refusal to comply with urine drug screenings can result in a medication change to my treatment plan.

_____ I agree to continue care by keeping all follow-up appointments.

_____ I agree to follow the Federal and State laws stating that it is a felony to share, sell, or exchange medications with anyone for any reason. It is also a felony to forge, falsify, or alter a prescription. If you violate these laws, you will forfeit your right to doctor-patient confidently on these matters and such actions will result in a report to the police, along with termination of care from this practice.

_____ New South Psychiatry, P.C. does not give controlled substance prescriptions for more than 30-days. Refills on controlled medications are dated 30 days from the fill date and will not be authorized for early refills.

_____ New South Psychiatry, P.C. will not replace lost or stolen prescriptions on controlled substances.

I acknowledge and understand the guidelines, policies, and procedures established by New South Psychiatry, P.C.

Signature: _____ Date: _____

Controlled Substance policies are subject to change, As Federal and State guidelines and laws make additional regulations or adjustments. These changes will be communicated from either your physician or a clinical staff member. New South Psychiatry, P.C. will remain in compliance with all Federal and State prescribing laws.

Financial Responsibilities:

I understand that any copayment, deductible, or coinsurance is collected prior to being seen by providers.

I understand that any amount unpaid after insurance reimbursements is the responsibility of the patient and agree to pay the amount due in full or make payments to New South Psychiatry, P.C. within 120 days.

I understand that if I opt for private pay, no bill will be submitted to my insurance company and that the full amount for private pay services will be due before services are rendered. Fee schedules can be found on our website or can be verbally given by staff. Private pay fees are not determined on a sliding scale.

Insurance Information:

Please be prepared to provide our office staff with a valid photo ID and insurance card so we may make a copy. failure to have a valid photo ID will result in cancellation of the scheduled appointment.

Primary Insurance

Name of Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN: _____ Insurance ID Number: _____

Group Number: _____ Client's relationship to subscriber: _____

Secondary Insurance (if applicable)

Name of Insurance Company: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____/_____/_____

Subscriber's SSN: _____ Insurance ID Number: _____

Group Number: _____ Client's relationship to subscriber: _____

I attest that the information provided is true to the best of my knowledge. I authorize mu insurance benefits to be paid directly to New South Psychiatry, P.C. and understand that I am financially responsible for any balance.

I authorize New South Psychiatry, P.C. to release any information required to process my claims.

Signature: _____ Date: _____

Insurance Reimbursement:

I understand that New South Psychiatry, P.C. will directly bill my insurance company, following my appointment.

Intake From:

Briefly describe your reason/reasons for seeking outpatient treatment _____

Client Information:

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____- _____- _____

Street Address: _____

City/State: _____ Zip Code: _____ Sex: _____
Phone Contact: Cell or Home Number: _____ May we leave a message? _____
Email Address: _____

Emergency Contact:

Name of Contact: _____ Phone Number: _____

Relationship: _____

I authorize New South Psychiatry, P.C. to contact the person/persons listed above in the event of an emergency.

Signature: ______ Date: _____

Medical and Mental Health History:

Are you currently being treated by a physician for any medical conditions? _____ if yes, please explain_____

Primary Care Provider: _____ Phone Number: _____

Are you currently taking any prescription, over the counter and/or herbal medication? _____ If yes, please list each medication name and dosage, one per line.

_____

_____

_____

_____

_____

_____

Authorization for Disclosure of protected Health Information:

- ❑ **I decline permission to verbally discuss my medical information with any other individual other than myself.**

I understand that any individual listed has the authority to access my PHI and can request information regarding my care and treatment.

- ♦ I _____ authorize New South Psychiatry, P.C. to disclose my health information to_____.

If you wish to have any health information shared with another physician or facility, please provide the physicians or facilities information.

- ♦ I _____ authorize New South Psychiatry, P.C. to disclose my health information with _____.

Name of individual or organization: _____

Address:
_____City/State/Zip_____

Phone Number: _____ Fax Number: _____

I authorize only the following record types of health information:

- ❑ Complete Medical Record
- ❑ Diagnosis
- ❑ Progress in treatment
- ❑ Medications
- ❑ Psychotherapy Notes

Signature: _____ Date: _____

I understand that this Authorization for Disclosure of protected Health Information is valid while I am under the care of New South Psychiatry, P.C.

I understand that I have the right to revoke this authorization, except to the extent that New South Psychiatry, P.C. has already made disclosures in reliance upon my prior consent.

I understand that any changes to revoke or add an individual must be made while in the office.

I understand that once I have revoked this consent the individual/individuals listed no longer have access to my PHI.

By signing below, **you agree with and understand** the clinical guidelines, policies, and procedures, as well as agree to comply with each guideline, policy, and procedure while under treatment at New South Psychiatry, P.C.

Signature: _____ Date: _____