

New South Psychiatry, P.C.

3209 Midtown Park S, Mobile AL, 36606

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

[www.newsouthpsychiatry.com](http://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 go 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.

## Controlled Substance Agreement

- I agree to random urine drug screenings and understand that any refusal to comply with urine drug screenings can result in changes to medications or treatment plans.
- I understand that any urine drug screenings that show inconsistent results in comparison to prescribed medications can lead to adjustments in treatment plans including discontinuation of controlled medications.
- I understand that any urine drug screenings that show illegal substance use can lead to adjustments in treatment plans including discontinuation of controlled medications. Illegal substances include cannabis, cocaine, MDMA, GHB, hallucinogens, heroin, inhalants, ketamine, methamphetamine, and any substances that is inconstant with prescribed medications.
- I agree to disclose any controlled substances that are prescribed by another provider. Including Suboxone, ketamine treatment, methadone, benzodiazepines, amphetamines, and narcotics.
- I agree to random alcohol testing and understand that any refusal to comply with screenings can result in changes to medications or treatment plans.
- I understand that inconsistent substance screenings can be confirmed with laboratory testing and that I am financially responsible for testing.
- I agree to continue care by keeping all follow-up appointments and understand that prescribed medications require observance to maintain safety.
- 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 understand that 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.

**By signing this document I acknowledge and understand the guidelines, policies, and procedures established by New South Psychiatry, P.C. and agree to honor the controlled substance agreement.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**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 my 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

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**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.

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**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: \_\_\_\_\_



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

**WHO WILL FOLLOW THIS NOTICE:** This notice describes our practices and that of (1) any healthcare Provider authorized to enter information into your medical record that we maintain at this office; and (2) all employees, staff, and other healthcare personnel.

**YOUR HEALTHCARE INFORMATION.** We create a record of the care and services you receive at this office. We need this record to provide you with quality service and to comply with certain legal requirements. This notice applies to all of the records about you maintained by this office. Other physicians or health care providers that you use may have different policies or notices regarding the use and disclosure of your medical information. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to (1) make sure that clinical information that identifies you is kept private; (2) give you this notice of our legal duties and privacy practices with respect to clinical information about you; and (3) follow the terms of the notice that is currently in effect.

**HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.** The following categories describe different ways that we use and disclose clinical information. "Use" is what we do with your information in this office. "Disclose" means sharing your information with your information in this office. "Disclose" means sharing your information with others outside this office. All of the ways we are permitted to use and disclose information will fall within one of the categories.

- **For Treatment.** We may use clinical information about you to recommend treatment or services. We may disclose medical information about you to doctors, nurses, technicians, office staff or other personnel who are involved in your care.
- **For Payment.** We may use and disclose clinical information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company, or a third party.
- **For Health Care Operations.** We may use and disclose clinical information about you as reasonably necessary. These uses, and disclosures are necessary to run the office and make sure that all of our patients receive quality care.
- **To You.** We must disclose your clinical information to you when you request it in writing, as described below. We may disclose your clinical information to you in other situations.
- **Opportunity to Agree or Object.** We may disclose your information in front of others with your informal permission when you are present. If you are not present or otherwise unable to give permission, we may disclose your medical information to others if, in a healthcare provider's professional judgment, disclosure is determined to be in your best interest. This includes telling family or friends involved in your care about your current medical condition. This also allows us to leave appointment reminders and messages with limited information on your voicemail and answering machine.





- **Incidental Use.** Although we try to limit communications of your medical information to the minimum necessary, we can disclose information that is incidental to an otherwise permissible use.
- **Valid Authorization.** We may disclose your medical information pursuant to your written authorization. For authorization to be valid, you must sign a form containing certain statements.
- **Law Enforcement.** We may disclose your Health Information if asked to do so by a law enforcement official (1) in response to a court order, subpoena, warrant, summons, or similar process; (2) about a death we believe may be the result of criminal conduct; (3) about criminal conduct at the office; or (4) in emergency circumstances, in order to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **Psychotherapy Notes, Marketing, and Sales of Protected Health Information.** Most uses and disclosures of psychotherapy notes, protected health information for marketing purposes, and that constitute a sale of protected health information require authorization.
- **Other.** Other uses and disclosures not described in this notice will be made only with your authorization.

**YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.** You have the following rights regarding medical information we maintain about you: • **Right to Inspect and Copy.** You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes prescriptions and billing records. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. We will select a licensed health care professional to review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about healthcare matters in a certain way or at a certain location.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact New South Psychiatry, P.C. at (251) 525-9090.
- **Right to Receive Notice of Breach.** You will receive notification of breaches of your unsecured protected health information unless we determine there is a low probability your PHI was compromised.

**CHANGES TO THIS NOTICE.** We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have



about you as well as any information we receive in the future. We will post a summary of the current notice in the office. The

summary will contain, in the top right-hand corner the effective date. You are entitled to a copy of the current notice in effect.

**OTHER USES OF HEALTHCARE INFORMATION.** Other uses and disclosures of information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your healthcare information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

By signing below, I acknowledge receipt and the opportunity to review New South Psychiatry, P.C.'s privacy practice.

\_\_\_\_\_  
Print Name of Patient/Client

\_\_\_\_\_  
Signature of Patient/Client

\_\_\_\_\_  
Date

OR

\_\_\_\_\_  
Signature of Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date