No show and late cancellation policy

Effective: October 17, 2017

According to our new missed appointment policy, after a missed appointment or cancellations with **less than a 24 hours'** notice, we will charge a **$25.00 fee** to your next and upcoming appointment in addition to your scheduled appointment fee. Missed appointments are costly to us and represent a missed opportunity for another client to be seen. While we value the opportunity to work with you, we must be sure to be reasonable and responsible with our schedule

Thank you,

Innovative Behavioral Health Services, P.C.

Patient Information Form Record #: ____________________

Please print all information in the spaces provided.

Last Name ______________________________ First Name _________________________ M.I.____

Home Address ____

City, State, Zip ____

Home Phone (   ) ______ - ______ Cell Phone (   ) ______ - _______

Employer Name and Address ____

Social Security Number Date of Birth Email _____________________

_____ - _____ - _____ ____/____/____

Primary Insurance

Company Name and Phone Number

____( ) ______ - ________

Billing Address

____

Name of Insured and Relation to Patient:

_______________________________________ Subscribers Date of Birth: ______________________

Subscriber ID Number: ________________________ Group Number ______________________________

Secondary Insurance

Company Name and Phone Number

____( ) ______ - _______

Billing Address

____

Name of Insured and Relation to Patient

____

Insured's ID Number ________________________ Group Number ________________________

Emergency Contact ____

Relation: ____________________________ Phone Number: (   ) ______ - _______

If you came to Innovative Behavioral Health Serveries by a referral, please list referral information below, so we might better coordinate your health care.

____

Client Self-Assessment

Name: ____	Today's Date: ______________________
Date of Birth: ______/______/______	Record #: __________________________

What brings you in today? ____

____

How long has this been going on? ☐ less than a week ☐ less than a year ☐ a year or more
Have you had mental health services before? ☐ Yes ☐ No
Is there any history of mental illness or substance abuse in the family? ☐ Yes ☐ No ☐ Unknown
Have you ever been hospitalized for psychiatric reasons? ☐ No ☐ Yes (dates: ______________________)

Mark with a check if you experience any of the following symptoms:

☐ Frequent feelings of worry	☐ Obsessions: __________	☐ Compulsions: ___________	☐ Phobia
☐ Panic attacks	☐ Nightmares	☐ Sense of doom	☐ Flashbacks
☐ Afraid to go outside	☐ Feeling jumpy	☐ Social anxiety	☐ Other: ________________
☐ Sadness	☐ Feelings of worthlessness	☐ Guilt feelings	☐ Crying
☐ Irritability	☐ Decreased concentration	☐ Has lost interest in things	☐ Low energy
☐ Thoughts of death/suicide	☐ Recklessness	☐ Impulsiveness	☐ Hyperactivity
☐ Decreased need for sleep	☐ Rapid speech	☐ Intense joy/excitement	☐ Other: ________________
☐ Frequent mood changes	☐ Difficulty trusting others	☐ Chronic feelings of emptiness	☐ Unstable relationships
☐ Frequent or intense anger	☐ Suicidal ideation/attempts	☐ Feeling paranoid	☐ Loneliness
☐ History of self-harm (cutting, burning, etc.)		☐ Other impulsive behaviors (shopping, sex, drugs/alcohol, etc.)	
☐ Hear voices	☐ See things that aren't there	☐ Read other people's minds/ Others can read your mind	
☐ Receive special messages from TV or radio		☐ Other: (specify: __________________________________)	

Substance Use

☐ Currently use a substance(s) (e.g. alcohol, marijuana, other drugs, etc.) (specify:_______________________________________)
☐ Have been treated for substance abuse (specify when and where: ____)

General Medical Information

☐ Asthma	☐ High blood pressure	☐ Heart conditions	☐ Pregnant
☐ Seizures	☐ Major illness	☐ Emphysema	☐ Hospitalization
☐ Loss of consciousness	☐ Dental needs	☐ Diabetes	☐ Hepatitis
☐ HIV/AIDS	☐ Other STDs	☐ Other (specify: _______________________________)	

☐ Current medications (specify: ____)
☐ Past medications (specify: ____)

o**ther concerns you want to make your provider aware of:** ____

____

Informed Consent Agreement for Service Delivery

Name: ____ Legal Guardian: ___________________________

Date of Birth: ______/______/______ Record #: ___________________ Insurance #: ____________________

I (we) give consent for __________________________ to receive services from INNOVATIVE BEHAVIORAL HEALTH SERVICES P.C. I (we) understand that this service is voluntary and that this consent may be withdrawn with written notification at any time.

INTERVENTIONS: I (we) agree to allow Innovative Behavioral Health Services P.C. staff to implement professionally accepted methods of interventions indicated by the client's and programs mutually agreed upon therapeutic treatment goal/plans, and have had the alleged benefits, potential risks, and possible alternative methods of treatment/habilitation explained to me in a manner I can understand. In the case of an emergency where the staff member has exhausted verbal de-escalation techniques and a client is still being physically aggressive, a threat to self or others, or is destroying property, the staff member will call 911 and request intervention by law enforcement.

FIRST AID / MEDICATION ADMINISTRATION: I (we) authorize Innovative Behavioral Health Services P.C. to provide and render first aid assistance to the client as deemed necessary by trained and certified staff. I (we) understand that, during the time Innovative Behavioral Health Services P.C. staff are with the client, Innovative Behavioral Health Services P.C. staff will not administer medicines, but may monitor administration of the medicine by the client or his/her guardian.

EMERGENCY CARE: I (we) authorize Innovative Behavioral Health Services P.C. to obtain emergency medical, dental, or mental health care for this client, if needed, until such times that I (we) can be reached to authorize further care.

FINANCIAL RESPONSIBILITY: I (we) understand that all services are charted to me (us) and are due at the time of service, unless other arrangements have been made in advance, which may include filing forms necessary to file with my (our) insurance carrier.

INSURANCE: I (we) authorize Innovative Behavioral Health Services P.C. to 1) release to insurance carriers necessary information regarding services provided by Innovative Behavioral Health Services P.C., and 2) process insurance claims generated in the delivery of services.

CLIENT'S RIGHTS: I (we) have been fully informed and/or have received a copy of the following documents: **Notification of Privacy Policies and Client's Rights**

AMENDMENTS: I (we) understand that this document may be amended, as needed, and that any such amendment will require the signature of the client or, if legally declared incompetent or being a minor, the legal guardian.

ACCEPTANCE: I (we) have read and/or have been clearly explained the terms, conditions, and agreements of this informed consent agreement and voluntarily accept them as stated or amended as specified below. This arrangement may be withdrawn at any time, but will not exceed one year after the date signed.

Expiration date of Informed Consent for Service Delivery: ________________ (not to exceed one year)

Client: ____ Date: ____________________

Legal Guardian: __________________________________ Date: ____________________

Witness: _______________________________________ Date: ____________________

Financial Agreement

Name: ________________________________	Legal Guardian: ______________________________
Date of Birth: ______/______/______	Record #: ____________________

Innovative Behavioral Health Services P.C. is committed to providing the highest quality care to our clients. As part of the delivery of services, we have established a financial policy that is designed to clarify the payment policies and practices of this agency.

As a courtesy to you, we will bill insurance companies and other third-party payers. After 60 days, you are responsible for the remaining balance, including any portion not covered by the insurance company or third-party payers.

Please read the following and initial:

_____ **CO-PAYS/DEDUCTABLES:** Co-pays and all other obligations are due at the time of service. This includes deductibles and other charges that are not reimbursed by the insurance company (these charges are often not known at the time of service, but once determined, they will be due prior to your next appointment.

_____ **ASSIGNMENT OF BENEFITS:** Your signature at the bottom of this form authorizes insurance benefits to be made directly to Innovative Behavioral Health Services P.C. This includes insurance and other third-party reimbursement.

_____ **RELEASE OF INFORMATION:** Your signature also authorizes Innovative Behavioral Health Services P.C. to disclose case records (diagnosis, progress notes, or other requested information) to your insurance company for the purpose of receiving payment. Access to this information will be limited to determining insurance benefits.

_____ **NO SHOWS:** Missed appointments or cancellations made less than 24 hours prior to the appointment will incur a $25.00 charge. Multiple missed appointments may result in the referral to another provider.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Client: ____ Date: ______________________

Legal Guardian: _______________________________________ Date: ______________________

If you have a question or concerns about the services provided in this office, please contact Ben Mastridge MSN, PMHNP-BC at 919-529-2474 (office) or 919-397-8800 (24 hour number), or in writing at Innovative Behavioral Health Services P.C., 402 North Main Street, Creedmoor, NC 27522. We'll make every attempt to address your concerns within 7 business days. If your needs/concerns are still not addressed, you may contact the North Carolina Division of Mental Health/Developmental Disabilities/Substance Abuse Services (www.ncdhhs.gov/mhddsas) and Advocacy and Customer Service Section: 919-715-3197 DHHS CARE-LINE 1-800-662-7030 (Voice/Spanish)

Client: ____ Date: ______________________

Legal Guardian: ______________________________________ Date: ______________________

Authorization for the Disclosure and Reciprocal Exchange of Information

Name: ____	Legal Guardian: ______________________
Date of Birth: ______/______/______ Record #: __________________	Insurance #: ___________________

I hereby authorize **Innovative Behavioral Health Services P.C.** (402 Main Street, Creedmoor, NC 27522-8815) to disclose and receive specific client information about me in a reciprocal exchange of information within the following:

Person/Agency	Address	Phone/Fax
Primary Care Provider:		

This data shall include (client initial by each type of information that may be released):

____ Psychological Evaluation	____ Diagnosis	____ Alcohol/Drug Treatment
____ Psychiatric Evaluation	____ Service Plan	____ Hepatitis
____ Screening	____ Progress Notes	____ Medication Information
____ Client Profile	____ HIV	____ Financial Reimbursement
____ Other/Disclosures made regarding:		

*Client must sign, whether a child or adult; information protected by Federal Regulations 42 CFR part 2.

Authorization for the Disclosure and Reciprocal Exchange of Information

I hereby acknowledge that Innovative Behavioral Health Services P.C. has not conditioned my treatment on signing this authorization, and that I may refuse to sign this authorization if I so desire. I also recognize that I retain the right to revoke this authorization except to the extent that the agency has already taken action in reliance on the consent. Once information is disclosed pursuant to this signed authorization, I understand that the HIPAA privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information, and therefore, may not prohibit the recipient from disclosing it. North Carolina General Statutes 122C-53 through 122C-56 indicate the exceptions that allow providers to break confidentiality and re-disclose records. The Innovative Behavioral Health Services P.C. Client Handbook describes the circumstances where disclosure is permitted or required by state or federal laws. Other laws, however, may prohibit disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. Part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. In the following cases, minors have the same rights as adults and have the right to release information without a parent's signature: emancipated minors, minors receiving substance abuse treatment, and/or minors receiving treatment without parental consent. I understand that if my record contains information related to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information.

If not revoked earlier, this authorization expires automatically on _______________ or one year from the date it is signed, whichever is earlier.

I have read this information and understand that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary and that I am the protected client or am authorized to act on behalf of the client to sign this document. I fully agree with the above stated terms. I understand that I may request a copy of this authorization once it has been signed.

Client/Legally Responsible Person: ______________________________ Date: _____________________

Relationship: __________________________

Authorization for the Disclosure and Reciprocal Exchange of Information

Name: ____	Legal Guardian: ___________________________
Date of Birth: _____/_____/_____ Record #: __________________	Insurance #: ____________________

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