PATIENT REGISTRATION FORM

Name:	**Date:**
Gender: Choose	Relationship Status: Choose
If patient is a minor, name of legal guardian(s) or parent(s):	Race: Choose
Do both parents have legal decision-making rights? Yes	If not, who does?
Mailing Address:	
Date of Birth:	SSN:
Home	Is it ok to leave a message for you at this number? Choose
Mobile Phone:	Is it ok to leave a message for you at this number? Choose
Email:	Is it ok to email you? Choose
Current Employer:	Occupation:
Primary Care Provider:	PCP Phone:
Primary Insurance:	Insurance Phone:
Insurance ID#:	Group#:

Subscriber Name:	Subscriber DOB:
Subscriber SS#:	Patient's Relationship to Subscriber: Choose
Secondary Insurance:	Insurance Phone:
Insurance ID#:	Group#:
Subscriber Name:	Subscriber DOB:
Subscriber SS#:	Patient's Relationship to Subscriber: Choose
Emergency Contact:	**Emergency Contact Phone Number:**

I authorize Family Care Associates and its independent clinicians providing services for or under Family Care Associates to release of any medical or other information necessary to process a claim and/or for continuity of care purposes.

Signed_____ Date_____

Patient or Authorized Person's Signature

I authorize all third-party payments for services rendered to me by Family Care Associates to be paid directly Family Care Associates.

Signed_____ Date_____

Patient or Authorized Person's Signature

I have been given an opportunity to review and/or receive a copy of the ***HIPAA Notice of Privacy Practices***.

Signed_____ Date_____

Patient or Authorized Person's Signature

I understand that I am responsible for any co-pay, coinsurance, unmet deductible amounts and/or any fees not covered by insurance at the time of my scheduled appointment. I also understand that I will be responsible for the full fee for any missed appointment as stated in our Financial Policies.

Signed_____ Date_____

Patient or Authorized Person's Signature

OFFICE & FINANCIAL POLICIES

Our Practice

We are a group of licensed mental health professionals in private practice. Our office is open Monday – Friday 8a-8p, Saturday 9a-4p and Sunday 10a-4p. We are closed on all major holidays and may close in case of inclement weather. We see clients by appointment only. Appointments are scheduled according to the individual providers recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone **301-330-0006** or email **customerservice@alldaymedicalcare.com.**

If an appointment cannot be kept, please contact the office at least **48 hours in advance**. There will be a **$50.00 fee for late cancellations and a $75.00 fee for no shows.**

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Maryland Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration forms and our Notice of Privacy Practices explain the limits of confidentiality.

After Hour Emergencies

Our office number is 301-330-0006 If you need to speak with your doctor or therapist, please try to make your calls brief. Calls are accepted during business hours daily and 24 hours each day, 7 days a week by voice mail. After office hours, you can leave a message on the voice mail or email to **customerservice@alldaymedicalcare.com**. If immediate services are required, please call 911, or go to your nearest emergency department.

FEES AND PAYMENTS

Fees are standard and based on the complexity of your visit. Payment in full is required at the time of your visit and can be made with cash, Visa, MasterCard, American Express or Discover. Insurance co-payments and any outstanding balances are due at the time of service. We will not bill your secondary insurance for co-payments. If you are unable to pay your co-payment/deductible at your visit, your appointment may need to be rescheduled.

While filing insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Your insurance is a contract between you, your employer and the insurance company, we are not party to that contract. Before your visit, contact your insurance company to verify that we are participants in your plan, and that the services you intend to receive are covered. For us to file a claim, you must present a CURRENT copy of your Insurance Card at each visit and communicate any changes in your personal information.

Not all services are a covered benefit in all policies, so it is very important that you understand the provisions of your individual policy. **Knowing your insurance benefits is your responsibility**. Insurance companies decide on different services that they will not cover; therefore, we can't guarantee payment of all claims by your insurance company. Reduction or rejection of your claim does not relieve you of your financial responsibility unless required by law or our contract with your insurance company.

PLEASE NOTE: Each visit is documented in your medical record and a diagnosis is made by the provider. Diagnoses are made based on medical information, not based on the availability of coverage by Insurance Companies. To request a diagnosis, change solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and is considered insurance fraud.

Required at Check-In

Verify Personal Contact Information	Present Current Copy of Insurance Card and PictureID
Payment of any Outstanding Balance	Payment of Today's Visit

We will verify your coverage at each visit. If we are unable to do so, you will be considered self-pay and will be responsible for the cost of your visit.

Self-Pay

In order to address the needs of our patients without insurance and patients with coverage limitations, we offer a discount off our standard fees. This discount reflects the lower cost involved in billing and collections when a claim does not need to be submitted to a third-party payer. In order to qualify, **payment needs to be made in FULL** prior to or on completion of your visit or procedure. Any remaining balance is not eligible for a discount. This discount applies to all medical services provided and is offered only at time of service.

Fees:

Psychiatric Nurse Practitioner Initial Visit	$200.00
Psychiatric Nurse Practitioner Follow Up	$150.00
Therapist Initial Visit	$125.00
Therapist Follow Up	$85.00

Medical Records

In order to follow Maryland State law and HIPAA regulations, we charge $0.83 per page and also, few agencies may be charged $22.58 preparation fee, payable in advance, if you would like a copy of your records sent to you or another physician. If you request an electronic copy of your records, we will charge a reasonable fee based on the cost of producing the copy. The medical record copy fee policy is available upon request. As always, if a collaborating physician requests portions of your record to assist in your care, there is no charge.

We require a 48-Hour notice for cancellation. We will attempt to make a reminder call or text before your appointment. If the office does not receive your appointment confirmation 2 days prior to your appointment, your appointment will be cancelled by the clinic and you will need to reschedule.

_____ For late/same-day cancellations, you will be charged $50.00
(Initials)

_____ For No Shows, you will be charged $75.00
(Initials)

"No- Show" and late cancellation charges need to be paid in full prior to be seen.

_____Interest Charge - All delinquent accounts past 30 days are subject to a 6% interest rate.
(Initials)

_____Returned Check - Non-Sufficient Funds (NSF) checks are subject to a $25.00 fee (in addition to fees from your bank)
(Initials)

_____Collections Charge -Accounts that are not paid within 60 days from due date may be sent to our Collection unit and
(Initials) reported to the Credit Bureau. In addition to your outstanding balance, a $25.00 charge will be added to cover our costs. In addition, you may be terminated from the practice and refused service until your account is current. Should the account be referred to an attorney or sent to small claims court for collection, it will be patient's responsibility to pay reasonable attorney fees, court costs, collection expenses and all other costs incurred by Family Care Associates to collect balance owed.

ADDITIONAL OFFICE POLICIES AND FEES

Appointments:

- Appointment cancellations require 48-hour advance notice.
- 3 Repeated late cancellations or no-shows or excessive cancellation may lead to termination of care at the discretion of your provider.
- Late, or same-day, cancellations: $50.00
- No show to scheduled appointment: $75.00

Many services are not covered by regular insurance, and our office may provide such services for additional fees.

Paperwork and letters:

- Charges will be determined at the discretion of your provider and depend on the time required for chart review and completion, as

well as complexity.

- A typical hourly rate can be $150 per hour for Psychiatric Nurse Practitioner and $95.00 for Therapists billed in 15-minutes increments
- Each provider reserves the right to not complete requested paperwork or compose letters.

Requests for direct calls, or telephone consultations, from your provider:

- Depending on the schedule and policies of your provider, this service may not always be available.
- Please attempt to schedule an appointment with your provider. However, if your provider can return your request for a call, please note that fees may be charged, depending on time requirement and complexity.
- A typical hourly rate can be $150.00 per hour for Psychiatric Nurse Practitioner and $95.00 for Therapists billed in 15-minutes increments
- In the event of a true emergency, please call 911 or go to your nearest emergency room.

Medication requests, during office hours, and not during appointments:

- $25.00 charge, and up, depending on time and complexity
- After hours on-call services are not meant for routine medication refills. Refills called in for last minute cancelled appointments and after hours will incur a $25.00 charge, not covered by your insurance. The covering clinician may not always have access to your complete record to verify your prescription needs. Please limit refill requests to your office visits, or routine office hours.
- Prescription requests require advance notice of 48 to 72 hours for processing.
- Refill Medications will only be given for 7 days with the expectation that patient will schedule an appointment to see the provider to receive full refill of his/her medications
- Non-compliance with our policy may lead to discharge from our practice
- Prescriptions for certain controlled medications will only be provided during office hours.
- Each patient is responsible for maintaining the security of their prescriptions and medications. Reports of lost or stolen prescriptions are taken seriously and require additional time and resources to verify. Reports of lost or stolen prescriptions may be grounds for limitations of certain prescriptions, or for termination of care.

Prior Authorizations (PAs):

- Currently, there is no charge for PA's for medications and other treatments, though many medical offices do charge for this service.
- However, please be aware, as regular insurances continue to increase the burden of such requirements for both patients to receive care, and offices to provide routine care, a charge for this service may become necessary.
- We cannot guarantee that any prior authorization will be approved.

Worker's compensation claims are not done by providers in our office.

All fees subject to change without prior written notice.

Having read the above, I agree to abide by the office policies and fees set by Family Care Associates. My signature below confirms my reading and understanding ALL Office Policies, Procedures and Fees.

Patient Name Signature of Patient/Legal Guardian Date

CREDIT CARD AUTHORIZATION FORM

PATIENT NAME:_____ **DATE OF BIRTH:**_____

The purpose of this form is to authorize Family Care Associates to retain a valid credit card number on file for you as our patient. This form will be kept confidential and only authorized staff will have access to the information. *Please ask front desk for a copy of our Office Policies or see our policy on our website at www. AllDayMedicalCare.com.* ***If patient declines to provide credit card authorization a fee of $200.00 (for psychiatric services) and $125.00 (four counseling services) is due at the time of each visit. A claim will be filed with the insurance. If patient responsibility is less what was paid a refund will be issued to patient. If patient owes balance statement will be sent out.***

Your supplied credit care will be charged ONLY under the following circumstances:

1. FAMILY CARE ASSOCIATES reserve the right to charge the credit card listed below for all current patient balances, including co-pays (following insurance payments), co-insurances and deductibles. A receipt will be kept in your patient chart, unless directed to send the receipt directly to you. This notice serves as your consent to being charged for all current patient balances on your account.
2. If you, as the patient, miss a scheduled appointment without 48-hour notice to cancel or reschedule, FAMILY CARE ASSOCIATES reserves the right to charge the credit card listed below *$75.00* for our standard no-show fee and $50.00 for our standard cancellation fee. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any and all no-shows and cancellations. *As is customary, a representative from FAMILY CARE ASSOCIATES will call the phone number on file to remind you of your scheduled appointment. This reminder is usually done 48 hours prior to your scheduled appointment. It is the patient's responsibility to ensure we have a correct, current telephone number on file.*
3. If we receive notice that a payment is returned to us for any reason, FAMILY CARE ASSOCIATES reserves the right to charge the credit card listed below a *$25.00 returned check fee*. A receipt will be kept in your patient chart. This notice serves as your consent to being charged for any returned payments.
4. If you, as the patient, request paper records we will provide to you, upon written request, a paper copy of your medical record. FAMILY CARE ASSOCIATES reserve the right to charge the current medical records copying fees as set forth by the Maryland Board of Physicians. As of 2019 the current fee is $0.76 per page of the medical record and the actual cost of postage and handling of no more than $22.88. The office will provide you with a copy of your record. This notice serves as your consent to being charged for medical records request.

Other than the conditions mentioned above, under NO circumstance will FAMILY CARE ASSOCIATES charge your credit card for anything not discussed personally with you. In conjunction with HIPPA regulations, all credit card information will be confidentially kept within your medical chart in our office. Only authorized staff will be able to access this information.

Acknowledged, Agreed & Accepted

Having read this form and talked with the staff, my signature below acknowledges that I voluntarily give my authorization and consent to providing the requested information for my credit card to be charged accordingly for the conditions listed above.

Visa ☐ ***MasterCard*** ☐ ***Discover*** ☐ ***American Express*** ☐

*Credit Holder's Name:*_____

*Credit Card #*_____ *Expiration Date:*_____ *CVV2/CV*_____

This credit card on file is to be used for the following patient(s), please print name(s) below:

Patient Full Name:_____ DOB:____/____/____
Patient Full Name:_____ DOB:____/____/____
Patient Full Name:_____ DOB:____/____/____

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed above. This agreement will expire for multiple users on an annual basis. If continued authorization is requested, another credit card agreement can be issued, or a manager can verbally authorize and document the extension of an agreement.

_____ _____

Patient Signature (or person authorized to sign) Date

DECLINE PARTICIPATION

I,_____ decline to provide my credit and understand that I will be charged $200.00 (psychiatric services)/ $125.00 (counseling services) due at the time of each visit.

_____ _____

Patient Signature (or person authorized to sign) Date

TREATMENT CONSENT FORM

SERVICES OFFERED

PSYCHOTHERAPY

Psychotherapy, or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reduction, and a deeper insight into one's own life, values, goals, and development. It requires a great deal of motivation, discipline and work on both parties for a therapeutic relationship to be an effective one. Clients will have varying success depending on the severity of their complaints, their capacity for introspection, and their motivation to apply what is learned outside of sessions. Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings, and sensations such as guilt, anxiety, anger, or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived. At your initial visit, I will conduct a thorough review of your current complaints and of your background. By the end of the initial visit I will offer my preliminary impressions, and we will discuss your treatment options. Sometimes, psychotherapy alone will suffice. Often, however, a combination of psychotherapy and medication management is optimal (see below).

MEDICATION

Medications may be indicated when your mental symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, we will discuss with you all the medication options that are available to treat your current condition. We will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal affects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you. Medication therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy.

FREQUENCY AND DURATION OF VISITS

At your initial 45-minute visit, we will decide together the structure of your therapy. If medications are prescribed, or changed, we will conduct a 15-minute follow-up visit in two weeks. This is necessary to ensure proper administration and minimize any side affects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients on maintenance therapy, follow-up visits can be held at three-month intervals. If you are to undertake psychotherapy, weekly 45-minute sessions will provide the best results. We may discuss an alternate treatment structure depending on your circumstances.

To ensure better outcomes we recommend patients that are seeing a Psychiatric Nurse Practitioner to also schedule at a minimum a monthly appointment with one of our therapists.

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Forms and that you agree to abide by the terms stated above during our therapeutic relationship.

_____

Patient Name Signature of Patient/Legal Guardian Date

MEDICATION CONSENT FORM

I give my consent on_____(Date) for the psychiatrist/psychiatric nurse practitioner to prescribe medications to _____ (Patient's Name).

MEDICATIONS PRESCRIBED:

- _____
- _____
- _____
- _____

THE FOLLOWING WAS EXPLAINED/PROVIDED TO ME:

1. Benefits of Treatment and diagnosis information
2. Administration of Treatment
3. Alternative to treatment modes
4. Consequences of not receiving proposed treatment
5. I have been advised of the name, frequency, and potential side effects of the medications being prescribed to me.
6. I have been advised that if I am of Childbearing Age to avoid becoming pregnant while taking psychotropic medication, and to notify my psychiatrist immediately upon becoming pregnant.
7. I understand that certain medications are not F.D.A. approved for the specific indication, especially in children. Such uses are called off label uses and are not illegal.

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian Signature Date

Consent for Mental Health Treatment of Minors

If an individual has guardianship of a minor it is required to provide a copy of granted guardianship before services can be rendered.

If one of the parent's has full legal custody, a copy of the divorce/custody agreement would need to be submitted either by: **Fax 301-330-0006 Email: customerservice@alldaymedicalcare.com** or in person prior to beginning treatment for your child. Appointments will be rescheduled if the office has not received full legal custody/divorce agreement

Parent/Guardian #1

I,_____, do hereby authorize that my child,
(parent/legal guardian name)

_____, may receive mental health treatment (child's name)

provided under the establishment of Family Care Associates Services. I am aware that all custodial parents and legal guardians must give consent before treatment begins. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign Consent for Mental Health Treatment Form before the child can be treated.

Print Name _____

Parent/Legal GuardianSignature _____

Date _____

Parent/Guardian #2

I,_____, do hereby authorize that my child,
(parent/legal guardian name)

_____, may receive mental health treatment (child's name)
provided under the establishment of Family Care Associates Services. I am aware that all custodial parents and legal guardians must give consent before treatment begins. If the biological or legally adopted parents are currently separated or divorced, both parents would be required to sign Consent for Mental Health Treatment Form before the child can be treated.

Print Name _____

Parent/Legal Guardian Signature _____

Date _____

Patient Information and Informed Consent for Telepsychiatry Service

Telepsychiatry is the delivery of psychiatric (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements

- A computer/laptop/tablet and a webcam with microphone to video conference.
- Smart-phone

Potential Benefits

- Telepsychiatry provides convenience and increased accessibility to psychiatric care for individuals who are unable to be treated face to face due to temporary circumstances such as being away at college or an extended stay away from home or having a physical limitation preventing travel to our office.

Potential Risks

As with any medical procedure, there may be potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

- Therapy conducted online is technical in nature and problems may occasionally occur with internet connectivity. Difficulties with hardware, software, equipment, and/or services supplied by a 3rd party may result in service interruptions. Any problems with internet availability or connectivity are outside the control of the doctor and the doctor makes no guarantee that such services will be available or work as expected. If something occurs to prevent or disrupt any scheduled appointment due to technical complications and the session cannot be completed via online video conferencing, the doctor will call the patient back at the phone number provided on this form.
- Information transmitted may not be enough (e.g., poor resolution of video) to allow for appropriate medical decision making by the psychiatrist/psychiatric nurse practitioner or therapist.
- The provider may not be able to provide treatment to the patient using interactive electronic equipment nor provide for or arrange for emergency care that the patient may require, in cases of connection failure.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Although highly unlikely, security protocols can fail, causing a breach of privacy of confidential medical information.
- A lack of access to all the information that might be available in a face to face visit but not in a telepsychiatry session may result in errors in medical judgment.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
- I understand that the technology used by the provider is encrypted to prevent the unauthorized access to my private medical information.
- I have the right to withhold or withdraw my consent to the use of telepsychiatry during my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that the provider has the right to withhold or withdraw his or her consent for the use of telepsychiatry during my care at any time.
- I understand that all the rules and regulations which apply to the practice of medicine in the state of Maryland also apply to telepsychiatry.
- I understand that the provider will not record any of our telepsychiatry sessions without written consent.
- I understand that the provider will not allow any other individual to listen to, view or record my telepsychiatry session without my express written permission.

My Responsibilities

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I consent that at the time of service I, the patient will be physically present in the State of Maryland.
- I understand that I am solely responsible for maintaining the strict confidentiality of my user ID and password and I will not allow another person to use my user ID to access the Services. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation.
- I will not record any telepsychiatry sessions without written consent from the provider. I will inform the provider if any other person can hear or see any part of our session before the session begins.
- I understand that I, not the provider, am responsible for providing and configuring any electronic equipment used on my computer

which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins and I agree to revert to a telephone voice session utilizing the indicated telephone number provided below should a video connection not function properly.

- I have read and understand that all the clinic policies of Family Care Associates Services apply to all telemedicine as well as all in-person visits.
- I understand that I must establish a medical therapeutic relationship with my proposed telepsychiatry provider in Family Care Associates Service's office, face to face, prior to commencing telepsychiatry treatment.
- I consent to paying fees that are the same as an in-office visit for the type and length of service provided.
- I understand that a telepsychiatry appointment is scheduled the same as an in-office appointment would be, and should I not be available for the appointment or cancel it less than 48-hours in advance, there will be a charge for a missed appointment.

I have read and understand the information provided in the preceding pages regarding telepsychiatry. I have discussed this information with my provider and all my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telepsychiatry in my medical care and authorize the provider to use telepsychiatry in the course of my diagnosis and treatment.

Patient Name: First:_____MI:_____ Last:_____Date of Birth:_____/_____/_____

Address:_____, City:_____, State:_____Zip: _____

Patient's email address:_____Patient backup telephone contact: _____

Alternate phone number: _____

Signature:_____Date:_____
Patient/Legal Guardian

YOUR PATIENT RIGHTS

Welcome to our Practice. We respect our patients' dignity and pride. This document will explain your patient rights and responsibilities. It is part of your patient registration and is an important part of your health care plan. If you have any questions, please contact the Practice leadership.

Our commitment to you, our patient, includes the following rights. We comply with applicable Federal civil rights laws and affirm that we will deliver high-quality health care to every patient without regard to: age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, health condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

Considerate and Respectful Care

- Fair, high-quality, safe and professional care
- Care regardless of color, race, religion, creed, etc.
- Consideration, respect, and recognition of you and your individuality
- Treatment privacy
- Safe environment
- Private and discreet consultation, exam, and care. See Notice of Privacy Practices (NOPP) for the full list of privacy and security of health information/medical record rights

Health Status and Care

- Be informed of your health status in terms and/or language that you, your family, and caregivers can be expected to understand
- Take part and be active in your care and treatment plan
- Know, be told, and understand:
  - the names, roles, and qualifications of your health care experts that provide your care your follow-up care
  - risks, benefits and side effects of all medicines and treatment procedures for your diagnoses
- When and if the Practice recommends referrals to specialists or other health institutions:
  - to participate in your care
  - to know who these other health care places are and what they will do
  - to refuse their care
- To change providers or get a second opinion

Grievance

Discuss complaints, issues, or problems regarding services with your doctor and/or the Practice Management Team at 8945 N Westland Drive, Gaithersburg Maryland 20877. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Practice Management Team is available to help you.

YOUR PATIENT RESPONSIBILITIES

You are an important and active member of your care plan. You have certain responsibilities to yourself and to your care team. In the spirit of shared trust and respect, we ask you to:

- **Give true and complete information about your:**
  - Health status
  - Medical history
  - Hospitalizations
  - Medicines
  - Other matters about your health
  - Contact information, family members and caregivers and other needed information
- **Let us know:**
  - any risks about your care
  - Changes in your care, illness, or injury
  - Safety concerns
  - Violation of your patient rights
  - If you understand your care plan and what we expect from you
  - If you don't understand your care plan or its information

Please:

- Follow your care plan and instructions created by your doctor, nurses or other health care team members
- Keep appointments and, if you cannot make your appointments, let us know at a minimum 48 hours before your appointment
- Appointments not being confirmed 2 days prior will be cancelled by the office – Patients need to reschedule
- Patients will be discharged for 2 or more no-shows/late cancellations or excessive cancellations without proper notice
- Be responsible for your actions if you refuse care or don't follow doctor's orders
- Pay your health care bills in a timely manner
- Follow practice procedures, rules and regulations
- Be thoughtful of the rights of other patients and our staff
- Be respectful of yourself and our staff
- Treat the doctor and our health care staff with respect and consideration
- Accept that bad language or behavior is not tolerated and may be grounds for dismissal
- Accept we may end our relationship if you do not follow your clinician's orders

I have read and understand my rights and responsibilities

Patients Signature_____ **Patients Name**_____ **Date** _____

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral providers and your primary care physician (PCP), other behavioral health providers and/or facilities is important to ensure that you receive comprehensive and quality health care. This form will allow your behavioral health provider to share protected health information (PHI) with your other provider. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication, if necessary.

Patient Rights:

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization:

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. **This consent expires in twelve (12) months from the date of my signature below unless otherwise stated herein.**

Family Care Associates is authorized to release protected health information related to the evaluation and treatment of

_____

(Member Name) (Date of Birth – MM/DD/YYYY)

Provider Name: _____

Address:_____(Street)

(City) (State) (Zip Code)

Therapist Name:_____Therapist Phone: _____

Therapist Address: _____

(Street) (City) (State) (Zip Code)

Disclosure may include the following verbal or written information: (check all that apply)

- ☐ Laboratory/diagnostic testing results
- ☐ Medication records
- ☐ Behavioral health/psychological consult
- ☐ Psychiatric evaluation
- ☐ Psychosocial assessment
- ☐ Other
- ☐ Substance abuse treatment record
- ☐ Summary of treatment records & contact dates

I hereby refuse to give authorization for any release of information

Patient Signature_____**Patient Name**_____**Date**_____