COMPASS MENTAL HEALTH & WELLNESS

Experience Positive, Balanced Change

*Please complete the following 5 pages and give the office staff. Please print information clearly.*

**Patient Information**

First Name: _____ Last Name: _____

Date of Birth:_____ Age:_____ ☐ Male ☐ Female

Address: _____ Apt: _____

City: _____ State:_____ Zip: _____

Driver's License No. _____ Social Security Number: _____

Main Number: (_____) _____-_____ Ok to leave confidential message? ☐ **Yes** ☐ **No**

Alt. Number: (_____) _____-_____ Ok to leave confidential message? ☐ **Yes** ☐ **No**

Email:_____ (Used for appointment reminders)

**Pharmacy Name: _____ Address: _____ Phone Number: _____**

**Emergency Contact Information**

Name: _____ Relationship to Patient: _____ Phone #: _____

**Insurance Information**

Primary Policy

☐ **Indemnity** ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **EPO** ☐ **PPO** **Insurance Carrier:**_____

Insured's Name: _____ Insurance Phone #: _____

Insured's Relationship to Patient: _____ Member ID # _____ Group # _____

Secondary Policy*

☐ **Indemnity** ☐ **HMO** ☐ **PPO** ☐ **POS** ☐ **EPO** ☐ **PPO** **Insurance Carrier:**_____

Insured's Name: _____ Insurance Phone #: _____

Insured's Relationship to Patient: _____ Member ID # _____ Group # _____

* We reserve the right to bill only the primary insurance at our discretion.

**Consent for Treatment**

I, _____, give full consent to receive services until I notify my attending provider that treatment is no longer necessary. I certify that I have the legal right to seek and authorize treatment for myself.

Date:_____/_____/_____ _____

Today's Date Signature (Patient)

**AUTHORIZATION TO PAY BENEFITS**

I request that payment of authorized insurance benefits be made on my behalf to *Luciana Thompson, PNPMH-BC and Compass Mental Health & Wellness, LLC.* for professional services rendered to my dependent or me. I further understand that I am responsible for all outstanding charges not paid by my insurance. The undersigned is financially responsible for fees not paid pursuant to this agreement. I authorize any holder release of medical information as may be necessary for the completion of my insurance claims to any insurance carrier, health or hospital plan. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____

Insured or Responsible Party Today's Date

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## PATIENT'S RIGHTS

- You have the right to a comfortable environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
- You have the right to be treated with dignity and respect.
- You have the right to be told about the treatment you will be given, the risks, side effects, and benefits of all medications and treatment you will receive, the other treatments that are available, and what may happen if you refuse treatment.
- You have the right to accept or refuse treatment after receiving this explanation.
- You have a right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan.
- You have the right to know the qualifications of the staff responsible for your treatment.
- You have the right to refuse to take part in research without affecting your regular care.
- You have the right not to be given medication you don't need, or too much medication.
- You have the right to have information about you kept private and to be told about the times when the information can be released without your permission.
- Unless otherwise provided by law, you have the right to withdraw at any time your permission for something you agreed to earlier.
- You have the right to make a compliant and receive a fair response from this facility within a reasonable amount of time.
- You have the right to contact and consult with counsel at your expense.
- You have the right to select practitioners of your choice at your expense.
- You have the right to choose whether your parents may be present and participate in your treatment if you are at least 18 years of age.

*(The Patient's Rights handout is available upon request.)*

I acknowledge having read and understood the above patient rights.

_____ _____

Signature of Patient Date

_____ _____

Parent / Guardian / Authorized Representative Signature Date

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# OFFICE POLICIES

*We appreciate the opportunity to partner with you. The following information is provided for your benefit, so that we might serve you better.*

**OFFICE VISITS** - All office/outpatient visits or fees, are payable at the time of service. We accept cash, MasterCard, VISA, American Express, and Discover. (NO CHECKS) **(Initial) _____**

**COMMUNICATIONS** - For your convenience, we will offer appointment reminders via phone call, text, and/or email. Patients have the ability of opt-out of reminders at their request. Your provider may contact you via phone call or online video to discuss your care. **(Initial) _____**

**CANCELLATIONS** – **I agree to cancel my appointment at least 48 hours before my appointment time.** Failure to cancel prior to appointment time may result in a $50.00 no show fee. If I have multiple no shows or cancellations less than 48-hours prior to my appointment time, I understand I will not be scheduled and will be required to seek another provider. **(Initial) _____**

**MEDICATION REFILLS** - Medication(s) is/are prescribed to last until your next appointment. If you required medication refills you will need to be seen in office. We reserve the right to deny medication refills when appointments are not kept. **(Initial) _____**

**MEDICATION CHECKS** – Medication checks are scheduled for 15 minutes. Please be prompt for your appointment. If you are over 15 minutes late your appointment may be rescheduled. **(Initial) _____**

**PAPERWORK PREPARATION** - We charge for the completion of paperwork, letters, forms, etc. Fees will be determined by your provider. Fees are due at the time forms are submitted for completion. **(Initial) _____**

**MANAGED CARE PLANS** – In agreement with our managed care plans, all co-payments or fees must be paid at time of service. It is your responsibility to be aware of your coverage plan. Any denied coverage of visit amounts would be due immediately. *I am aware that I need to notify CMHW staff of any changes in my insurance at least 48 hours prior to my appointment.* New insurance without verification will result in a co-pay of the allowable amount designated by your insurance company. **(Initial) _____**

**DISRUPTIONS** - For the comfort of our patients and staff, disruptive clients and/or visitors (including children) will be asked to leave. Patients will be required to reschedule your appointment. **(Initial) _____**

**LANGUAGE** - We address all patients, visitors, and guests with courtesy and respect. Disrespectful or abusive language when speaking with staff will not be tolerated and may result in a patient being discharged from care. **(Initial) _____**

**FEMALE PATIENTS** – If taking medications, I agree to notify my provider if I am planning to become pregnant or I become pregnant so that I may discuss the risks/benefits of medication. **(Initial) _____**

**ALCOHOL/DRUGS/HERBAL SUPPLEMENTS** – It is recommended not to use alcohol/drugs in combination with prescription psychiatric medication and I agree to notify my provider of any usage. If I am using herbal supplements, I agree to notify my provider to prevent possible interactions with prescribed medications. **(Initial) _____**

**EMERGENCY SERVICES** – I agree to contact ***my provider and 911*** if I feel suicidal or violent in order to follow steps to protect the safety of others and myself. **(Initial) _____**

**BILLING/RECORDS INQUIRIES** - Questions about billing, records, account information and past due balances should be directed to our office at (281) 836-5452. **(Initial) _____**

**LABORATORY/ DIAGNOSTIC TESTING** –This office is not responsible for obtaining authorization for these tests. Please contact your insurance company for a listing of preferred providers. **(Initial) _____**

**I have read and understand the above policies and agree to the terms regarding payments and responsibilities.**

_____ _____

Signature of Patient Date

_____ _____

Parent / Guardian / Authorized Representative Signature Date

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# AUTHORIZATION TO DISCLOSE TO PRIMARY CARE PHYSICIAN (PCP)

Communication between your behavioral health provider(s) and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows your behavioral health provider to share valuable information with your PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider. (***Please check one of the following***)

☐ **NO, I do not** have an existing primary care physician. ***(If checked, please skip the boxes below and sign and date the form)***

☐ **YES, I do have a PCP**: (***If checked, please fill in the formation in the box below***)

**PCP Name:** _____

**Practice Name:** _____

**PHONE: (_____)_____-_____FAX (_____)_____-_____**

**Address:** _____

**City:_____, State:_____Zip:** _____

I,_____ _____/_____/_____
(Patient name – Print) (Patient DOB)

☐ **AUTHORIZE** ☐ **I DO NOT AUTHORIZED**

**COMPASS MENTAL HEALTH & WELLNESS** to disclose any applicable behavioral health information (including diagnosis, treatment plan, prognosis and medication(s) to the PCP indicated in the box above for the purpose of collaboration of care. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature**,** unless another date is specified. I have read and understand the above information and give my consent.

_____ _____
**Patient Signature (Patient over 18)** **Date (Required)**

_____ _____
**Personal Representative (if applicable) Signature** **Relationship to patient (Required)**

***PATIENTS – DO NOT WRITE BELOW LINE***

To: Dr._____,

A psychiatric evaluation was conducted on our mutual patient (name above) on _____ / _____ /_____ with the following Working Diagnosis: _____. Medication(s)/dosage(s) initiated: _____ Labs/tests ordered: _____

☐ I have requested that this patient consult you RE: _____

I have consent from the patient to communicate with you to facilitate collaboration of care. Please feel free to contact me at (281) 836-5452.

Sincerely,

Luciana Thompson, MSN, APRN, PMHNP-BC

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# AUTHORIZATION TO DISCLOSE TO BEHAVIORAL HEALTH PROVIDER

Communication between our behavioral health provider and your other existing behavioral health providers is important to make sure all care is complete, comprehensive, and well-coordinated. This form allows us to share valuable information with your existing behavioral health providers. No information will be released without your signed authorization. Once completed and signed, please give this form to our staff. **(*Please check one of the following*)**

☐ **NO, I do not** have an existing primary care physician. ***(If checked, please skip the boxes below and sign and date the form)***

☐ **YES, I do have ☐ Therapist ☐ Psychologist ☐ Counselor**: (***If checked, please fill in the formation in the box below***)

**Providers:** _____

**Practice Name:** _____

**Phone: (_____)_____-_____Fax: (_____)_____-_____**

**Address:** _____

**City:_____, State:_____Zip:** _____

I,_____ _____/_____/_____
(Patient name – Print) (Patient DOB)

☐ **AUTHORIZE** ☐ **I DO NOT AUTHORIZED**

**COMPASS MENTAL HEALTH & WELLNESS** to disclose any applicable behavioral health information (including diagnosis, treatment plan, prognosis and medication(s) to the PCP indicated in the box above for the purpose of collaboration of care. I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire six (6) months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent.

_____ _____
**Patient Signature (Patient over 18)** **Date (Required)**

_____ _____
**Personal Representative (if applicable) Signature** **Relationship to patient (Required)**

***PATIENTS – DO NOT WRITE BELOW LINE***

To: Dr._____,

A psychiatric evaluation was conducted on our mutual patient (name above) on _____ / _____ /_____ with the following Working Diagnosis: _____. Medication(s)/dosage(s) initiated: _____ Labs/tests ordered: _____

☐ I have requested that this patient consult you RE: _____

I have consent from the patient to communicate with you to facilitate collaboration of care. Please feel free to contact me at (281) 836-5452.

Sincerely,

Luciana Thompson, MSN, APRN, PMHNP-BC