ARBOR PSYCHIATRIC AND WELLNESS CENTER

PATIENT INFORMATION

First Name: _____ Last Name: _____ Middle Initial: ____

DOB: ____-_____-____ Age: _____ SSN: _____-_____-_____ Marital Status: S M W D

Mailing Address: _____

City, State, Zip: _____

Home Phone: _____ Cell Phone: _____

E-mail: _____

I consent to receive communication using voicemails, text messages, and email (Initial) _____

Parent/Guardian Name:_____

SSN:_____-_____-_____ DOB: _____/_____/_____ Phone: _____

Email: _____

Emergency Contact

I consent for communication with my emergency contact in the event I cannot be reached for emergency safety concerns, appointments, billing, or other concerns related to managing my care.

Contact Name: _____ Relationship: _____

Phone: _____ Email (if applicable): _____

Responsible Party/Primary Insurance Information

Primary Insurance: _____Name of Subscriber: _____

Subscribers DOB: _____ ID #: _____ Group #: _____

Subscriber Address: _____

Subscriber Employer: _____

If applicable, Secondary Insurance: _____ ID #: _____

I authorize Arbor Wellness, LLC, Mindz, Inc., (Lindsey Teten, APRN), and/or Bennett Counseling Services (Pam Bennett, LCSW) to release any information acquired in the course of examination and treatment to my insurance carrier. This authorization shall remain valid until my written notice is given revoking the authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This signature will also authorize consent to treatment for the above-named individual.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

ARBOR PSYCHIATRIC AND WELLNESS CENTER

OFFICE POLICY AGREEMENT

Please initial each of the following statements to acknowledge that you understand and accept these terms:

_____ I consent to treatment for myself or the below named individual.

_____ I understand that the provider I am seeing is an independent contractor of Arbor Psychiatric and Wellness Center (Arbor Wellness, LLC), not an employee.

_____ I allow Arbor Wellness, LLC, and my providers representative to file for insurance benefits to pay for the care I receive.

_____ I understand the following terms of treatment:

- I understand that I have the right to refuse any treatment or procedures.
- While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and or mental health treatment; I realize that particular results cannot be guaranteed.
- Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make life changes.
- I have the right to discuss all medical treatments with my provider.

_____ EMERGENCY SERVICES. Arbor Psychiatric and Wellness Center is not an emergency clinic. After hours, holidays, and weekends, I am to contact 911 or go to the nearest emergency room in the event of a mental health crisis or emergency. My providers are accessible through a 24-hour answering service if there is an urgent need.

_____ PROVIDER CONTACT. I consent to communication between myself, Arbor Psychiatric and Wellness Center staff, and my provider using the following methods: telephone, voicemail, email, text messaging, videoconferencing, and website/portal.

- I have been provided and fully understand and accept the risks, limitations, conditions of use, and instructions for use of the selected electronic communication services more fully described in the Appendix to this consent form.
- I consent to the conditions and will follow the instructions outlined in the Appendix, as well as any other conditions that my provider or office staff may impose on communications with patients using the services listed above.
- I acknowledge and understand that despite recommendations that encryption software be used as a security mechanism for electronic communications, it is possible that communications with my provider or office staff using the services may not be encrypted.
- Despite this, I agree to communicate with my provider or office staff using these services with a full understanding of the risk. I acknowledge that either I or my provider or office staff may, at any time, withdraw the option of communicating electronically through the services upon providing written notice.
- Providers at Arbor Psychiatric and Wellness Center will do their best to respond to calls and e-mails as soon as possible. Calls and emails must address immediate concerns and are not a substitute for an office visit.

_____ FINANCIAL POLICY. Acceptable methods of payment include cash, check, or credit card. I will be asked to sign credit card authorization to allow credit card information to be stored in a secure vault and accessed for payment of future debts.

- Copays must be paid at time of visit.
- All balances should be paid within thirty days of receiving statement. I may be required to pay a portion of the balance before being seen if balance is more than thirty days overdue.
- Past due accounts and non-payment may result in medication delays.
- There is a $25 fee for returned checks.
- If your account becomes past due, we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed for non-payment as a patient from our office.
- We offer a self-pay fee schedule at a discounted rate. Fees are subject to change. I understand I can request the most updated self-pay rates.

_____ **MISSED APPOINTMENTS AND LATE CANCELLATIONS.** Failure to keep your scheduled appointment will result in a fee of $50, unless you cancel at least twenty-four (24) hours prior to the appointment time. This fee cannot be waived more than once. Showing up late (more than 10 minutes) for an appointment may result in immediate cancellation of that appointment. Failure to show for your appointment two times may result in termination of services. Please note that appointments are necessary to obtain refills. Frequent missed or canceled appointments will result in the denial of refill requests.

_____ **MEDICATIONS**. We must follow the rules and regulations of the DEA in prescribing medications. We aim to practice responsible medicine and "do no harm", therefore, at times it may be necessary to take action or precautions against potential abuse or dependency of controlled substances. If you have multiple prescriptions for controlled substances or there is a cause for concern of abuse of controlled substances, you may be asked to sign a controlled substances contract. You may be required to submit a urine drug screen before controlled substances are prescribed or at any time during treatment. Events that may cause concern may include but are not limited to early refill request, prescriptions being filled for same type of medication by multiple providers, appearance or concern of overuse of medications. Our providers reserve the right to terminate treatment with a controlled substance at any time.

_____ **MEDICATION REFILLS**. It is important to keep your scheduled appointment to ensure that you receive timely refills. No shows or repeated cancellations will result in a denial of refills. It is always best to call for a refill at least 3-5 days prior to when your supply of a medication will run out. The most efficient way to request a refill on most medications is to call your local pharmacy. The pharmacist will then contact our office for approval. Our prescriber may not be in the office every day; therefore, prescriptions may not be filled until the next clinic day.

_____ PROTECTED HEALTH INFORMATION. It is important to our providers and staff that you understand how your protected health information (PHI) may be accessed by your providers.

- NeHII is a state-wide, internet-based, health information exchange. NeHII is sponsored by Nebraska health care providers and health insurers who share and use your information for treatment, payment or health care operations purposes. Using NeHII, participating providers and health insurers can see certain health, demographic and payment information (your health information) in each other's records. They can use this information for treatment, payment or health care operations purposes. Arbor Psychiatric and Wellness Center providers participate in this initiative. Because of this, all patients are included in the NeHII information exchange unless they specifically request to opt-out of NeHII.
- I understand I am authorizing my provider to access all of my PHI maintained in the CHI Health Systems EPIC electronic health record. This access is for treatment related purposes only. I understand that all records contained in the CHI Health Systems EPIC electronic health record system (which may contain records from all other facilities and affiliated sites) will be available to view by your provider. These records will include (but are not limited to) your demographic information, insurance information, labs, prescriptions, medical diagnosis and clinical notes. Sensitive Medical Information. Access includes mental health records, pregnancy, HIV, sexually transmitted diseases, genetic testing information, or alcohol and/or drug abuse treatment information. Records from other providers outside of CHI Health Systems that may be included in your medical record will also be available for viewing by your provider.

By signing below, you certify that you have read and understand the terms stated in the above agreement. You indicate that you understand the above policies for emergency services, provider and office staff contact, financial agreement, missed appointment and late cancellations, medication prescribing and medication refills, as well as that you agree to the use and access of your PHI.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

Witness: _____Date: _____

ARBOR PSYCHIATRIC AND WELLNESS CENTER

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient you have the right to:

- Include or exclude family members/significant others in all aspects of your care.
- Be treated with compassion, dignity, and respect.
- Be informed of your treatment including benefits, risks, and reasonable alternatives as well as the risks if treatment is refused.
- Participate in the decisions of your treatment plan.
- Understand the treatment modalities being used in your treatment, as well as their benefits and consequences.
- Waive the privilege of confidentiality by signing a release of information.
- Refuse treatment.
- A clear understanding of fees associated with care.
- Be free from verbal, physical, psychological, and sexual abuse.
- Confidentiality to the extent to which the law allows:
  ◊ Exceptions include: suspected child/elder abuse/neglect, potential harm to oneself or others, court ordered treatment and instances when the court subpoenas records.
- Receive an explanation and understand the benefits and/or side effects associated with the use of medications being prescribed.

As a patient you have the responsibility to:

- Provide accurate and complete information about your present complaints, past illnesses, prior hospitalizations, types of medication(s) currently using or have used in the past, and other health related issues to your provider.
- Accept responsibility of your decision if refusing treatment.
- Treat others with dignity and respect, including staff, other patients, and providers.
- Respect the property of other persons and Arbor Psychiatric and Wellness Center.
- Assume responsibility for financial obligations.
- Understand and participate in your treatment plan.
- Attend all scheduled appointments and to give 24-hour notice to cancel or reschedule. Understand confirmation calls/notifications are done as a courtesy. Failure to call may result in your discharge from care at Arbor Psychiatric and Wellness Center, being charged a no show fee no less than $50.00 per appointment.
- Ask questions about your care.
- Follow your treatment plan.
- DO NOT bring alcohol, drugs, weapons, or sharp objects to your appointments.

Print Patient Name: _____ Date of Birth: sadf

Signature of Patient/Guardian: _____ Date: asdf

Witness: _____Date: _____

ARBOR PSYCHIATRIC AND WELLNESS CENTER

ACKNOWLEDGEMENT OF PRIVACY PRACTICES AND CONSENT FOR TREATMENT

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that my provider and Arbor Wellness, LLC, may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization. Arbor Wellness, LLC has a detailed document called the *'Notice of Privacy Practices'*. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask I will be provided with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature also means that I agree to allow Arbor Wellness, LLC and my provider to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Arbor Wellness, LLC and my provider has taken action relying on this consent.

My signature indicates I understand my rights as a patient and understand that these rights may be limited by certain legal policies implemented to protect my safety, I also understand and agree to all the specified clinic rules and procedures and acknowledge that failure to follow such guidelines on my behalf as a patient may result in termination of my treatment.

I, the patient or patient's legal representative, hereby grant permission for the independent contractors at Arbor Psychiatric and Wellness Center to perform such examinations, medical, and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations.

I am aware that healthcare is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examination. I understand that there are inherent risks in pharmacologic treatment and that there may be adverse side effects and results that are not anticipated. Hereby, I consent to be treated with knowledge of possible risks and understand that I will be informed of possible adverse effects when applicable.

Print Patient Name: _____ Date of Birth: _____

Signature of Patient/Guardian: _____ Date: _____

Witness: _____Date: _____

1120 6th Corso Nebraska City, NE 68410
P: 402.713.0110 | F: 402.713.0285

ARBOR PSYCHIATRIC AND WELLNESS CENTER

CREDIT CARD AUTHORIZATION FORM

In adherence to our clinic policy, we ask each patient to keep a credit card authorization form on file in the event that you cannot or do not pay fees that are outstanding, remain as part of your visit, or as it pertains to any no show fees. This form will be kept confidential and only authorized staff will have access to this information.

Your signature below indicates your agreement and consent to charge your credit card for any outstanding charges for any service fees which may include no shows, phone services, and other fees as outlined in clinic policies and procedures.

I, _____ (*name as it appears on the credit card*), authorize Arbor Psychiatric and Wellness Center to submit any charges for professional services that are rendered to _____ (*full legal name of patient*) to my credit card. This authorization applies to all legitimate charges for any individual whom I have accepted financial responsibility and includes all current and future outstanding charges.

I understand that Arbor Psychiatric and Wellness Center reserves the right to charge the credit card listed below for all current or past due balances, including co-pays, co-insurances, deductibles, and no-show fees. If charges or balance exceeds $50, Arbor Psychiatric and Wellness Center will charge the credit card listed below $50/month until the balance is paid off or if other payment terms have been agreed upon. This notice serves as your consent to being charged for all current and past due patient balances on your account.

I understand that I can request a receipt for charges and updated statements at any time by phone, email, or mail. This authorization will not expire and can be withdrawn in writing at any time.

Name on Credit Card: _____

Type of Credit Card: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____/_____ Card Verification Data: _____ (3 digits on back)

Zip Code applicable to Credit Card: _____

Full legal name of patient authorized for use:_____

Signature of Cardholder: _____

Date: _____ Staff Initials: _____

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ARBOR PSYCHIATRIC AND WELLNESS CENTER

AUTHORIZATION FOR EVALUATION AND/OR TREATMENT OF A MINOR CHILD UNACCOMPANIED BY PARENT OR LEGAL GUARDIAN

A parent or legal guardian must accompany a child younger than 19 years of age to consent for all medical and/or psychotherapy treatment given by contracted providers at Arbor Psychiatric and Wellness Center.

Please complete this form if your child will be coming for a psychiatric or psychotherapy visit, without a parent or legal guardian.

**It is required that parent(s) or legal guardian attend the intake appointment with any new provider.

MINOR PATIENT INFORMATION:

First Name: _____Last Name: _____ DOB: ____-____-____

Mailing Address: _____

City, State, Zip: _____

Phone (in case of emergencies): _____

I authorize and give consent for my child, listed above, to go independently to appointments and consent to all psychiatric and psychotherapy treatments without the presence of a parent or legal guardian.

I understand that this written consent is valid until the patient turns 19. This consent may be revoked by me at any time in writing.

I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments.

Print Guardian Name: _____

Signature of Guardian: _____ Date: _____