PATIENT INFORMATION

DEMOGRAPHIC INFORMATION

Last Name: _____ First Name: _____ M.I: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone: _____ Home Phone: _____

Work Phone: _____ Cell Phone: _____

Birth Date: _____ Sex: _____ Social Security #: _____

Marital Status: _____ Spouse Name: _____

Primary Care Physician: _____ Physician Phone: _____

Were you referred by someone? If so, who? _____

Employer: _____ Employer Phone: _____

EMERGENCY CONTACT

Name: _____ Relationship: _____

Address: _____

Home/Cell Phone: _____ Work Phone: _____

PRIMARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____

Policyholder's Last Name: _____ First Name: _____ M.I: _____

Address: _____ Phone: _____

ID #: _____Group #: _____

Policyholder SS #: _____ Relationship to Patient: _____

Policyholder DOB: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone #: _____

SECONDARY INSURANCE

Name of Insurance Company: _____ Phone: _____

Address: _____

Policyholder's Last Name: _____ First Name: _____ M.I: _____

Address: _____ Phone: _____

ID #: _____Group #: _____

Policyholder SS #: _____ Relationship to Patient: _____

Policyholder DOB: _____ Insurance Effective Date: _____

Employer's Name: _____ Phone #: _____

CHECKLIST OF CONCERNS: PLEASE MARK ALL ITEMS AND/OR ADD ADDITIONAL ITEMS AT THE BOTTOM OF THINGS THAT APPLY TO YOU.

- ☐ I have no problem or concern bringing me here
- ☐ Abuse – physical, sexual, emotional, neglect
- ☐ Aggression
- ☐ Alcohol use
- ☐ Anger/irritability
- ☐ Anxiety
- ☐ Attention, concentration or distractibility
- ☐ Career concerns
- ☐ Codependence
- ☐ Compulsions
- ☐ Depression, sadness, low mood
- ☐ Divorce/Marital
- ☐ Drug use
- ☐ Eating concerns
- ☐ Fears/Phobias
- ☐ Financial stress
- ☐ Friendships / relationships
- ☐ Grief and loss
- ☐ Physical ailments
- ☐ Interpersonal conflicts
- ☐ Fertility
- ☐ Obsessions
- ☐ Parenting
- ☐ School issues
- ☐ Self-esteem
- ☐ Spiritual, religious, moral, or ethical
- ☐ Stress
- ☐ Suicidal thoughts or plans / self-harming
- ☐ Other

FINANCIAL POLICY

Thank you for choosing Room 2 Grow as your behavioral health care provider. We are committed to providing you with the highest quality of care at competitive prices. In order for us to continue to do this, it is very important that you review the Financial Policy that all patients are required to read and sign prior to their treatment.

Patient Information Form - Please provide all of the information requested on the Patient Information form. Some of this information will help ensure correct billing to your insurance carrier. Some will allow us to contact you in the unlikely event that your appointment needs to be canceled. It is your responsibility to inform us immediately if any of this information changes. It is particularly important that you notify us of any changes in your insurance coverage. If you do not do so, we may not be able to obtain authorizations or file claims within your insurance company's timely filing deadlines. In that event, any unpaid fees will become your responsibility.

Insurance Plans - We participate with most insurance plans. However, it is your responsibility to check with your insurance company prior to treatment to make sure that your policy covers our providers and services. In some cases, insurance companies require preauthorization prior to your seeking treatment.

Benefits Interpretation - We will do our best to help you interpret your health care benefits, but it is ultimately your responsibility to understand which services are covered and which are not. If you have any questions about this, please ask your provider for help.

Billing Your Insurance - If we are participating providers for your insurance plan, we will bill the insurance company for you. If we are not, or if you do not have insurance, you will be expected to pay for your services in full at the time of your visit. We accept cash, personal checks, or credit card payments. There is a $25 fee for returned checks. We offer superbills for you to submit to your insurance for out of network benefits for reimbursement.

Copayments, Coinsurance & Deductibles – These charges must be paid at the time of your scheduled appointment.

Balances After Your Insurance Has Paid - If there is a balance after your insurance(s) has paid, you are responsible for payment of this balance. If we know what this balance will be at the time of your appointment, you are expected to pay at that time. Otherwise, we will send you a statement in the mail. Payment is due upon receipt. Disputes about reimbursements must be resolved between you and your insurance company. Room 2 Grow reserves the right to discontinue services to you if your account is more than 30 days past due or if payments owed at the time of service are not paid. Accounts more than 90 days past due or with undeliverable addresses may be forwarded to a collections agency for recovery. A $30 collections fee will be added to account balances forwarded to a collections agency.

Account Responsibility - It is our policy to bill the patient or patient's guarantor for any balances left on the account. If the responsible party fails to make timely payments on the account, we reserve the right to discontinue treatment. If you do not have insurance, you are personally responsible for your own debt and payment is expected at the time of service. In the case of minor patients, the adult signing this form is responsible for all patient balances, including payments due at the time of service.

Appointment Responsibility - If you need to change your appointment, we require at least 24 business hours' notice to avoid a charge. The charge for a missed appointment or late cancellation is $50 for the service that was scheduled. This charge will be due prior to the next scheduled appointment or upon receipt of an invoice, whichever is sooner.

Questions About Your Bill - If you have questions or require information about your bill, please contact us at 412.525.6594 between the house of 9-5 Monday through Friday.

PATIENT INFORMATION, FINANCIAL POLICY SIGNATURE, AND AUTHORIZATION OF PAYMENT OF BENEFITS

I have completed Room 2 Grow's Patient Information form to the best of my ability with accurate information, including insurance policy details. I have read Room 2 Grow's Financial Policy and agree to its terms.

I request that payment of authorized benefits be made to Room 2 Grow for any services provided to me or to another for whom I am guarantor or legal guardian. I understand that I must promptly notify Room 2 Grow of changes to my insurance coverage or to the coverage of the person for whom I am guarantor or legal guardian. I acknowledge that I am financially responsible for the payment of deductibles, coinsurance, copayments, and any other charges not paid by my insurance plan or the insurance plan of the person for whom I am responsible, including any non-covered charges, such as missed appointment fees. I authorize the release of medical information to the insurance carrier and its agents for the purpose of determining which of these services are covered.

Authorization must be signed by the patient or by an authorized person when the patient is a minor or is physically or mentally challenged.

_____ _____

Signature Date

_____ _____

Print Full Name Relationship to Patient

PATIENT'S RIGHTS AND RESPONSIBILITIES STATEMENT

PATIENT RIGHTS

- Patients have the right to receive considerate and courteous care, with respect and dignity for personal privacy.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability or source of payment.
- Patients have the right to expect their provider's team of workers to provide or to help them arrange for all of the mental health care that they need.
- Patients have the right to participate in the mental health care process and to be informed of their diagnosis and treatment.
- Patients have the right to information that they understand and to participate in decisions involving their care.
- Patients have the right to receive enough information to talk openly with their provider about appropriateness and medically necessary treatment options and be able to make a thoughtful decision prior to treatment, regardless of cost or benefit coverage.
- Patients have the right to confidential records, except when disclosure is required by law or permitted in writing by them with adequate notice. They have the right to review their mental health records with their provider.
- Patients have the right to express a complaint and receive an answer to the complaint within a reasonable period of time.
- Patients have the right to expect that emergency procedures will be implemented without any unnecessary delay.
- Patients have the right to make recommendations regarding Vista Behavioral Health Associates Patients' Rights and Responsibilities

PATIENT RESPONSIBILITIES

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to carefully read all of their member literature or contact their insurance carrier and ensure that they understand their benefits and policy requirements.
- Patients have the responsibility to communicate openly with the provider, ask questions, make certain they understand the explanations and instructions they are given and develop a provider-patient relationship based on trust and cooperation.
- Patients have the responsibility to help maintain their mental health and consider the potential consequences if they refuse to comply with treatment plans and recommendations.
- Patients have the responsibility to follow the agreed upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to not take actions that could harm others.
- Patients have the responsibility to keep scheduled appointments or give 24-hour notice of cancellations and adequate notice of delay.
- Patients have the responsibility to help providers maintain accurate and current records by being honest and complete when providing information, including information about all mental health insurance coverage.
- Patients have the responsibility to express their opinions, concerns or complaints in a constructive manner to the appropriate people.
- Patients have the responsibility to pay any applicable copayments, coinsurance or other fees at the time services are rendered. Ø Patients have the responsibility to inform their provider about problems with paying fees.
- Patients have the responsibility to report abuse or fraud.

I have read and understand my Rights and Responsibilities:

_____ _____

Signature Date

Authorization to Disclose Information to Primary Care Physician and Insurer

I understand that my records are protected under the applicable state law governing healthcare information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, _____hereby authorize Room 2 Grow to:
(Print Patient's Name)

Please check ALL that apply:

Primary Care Physician

____ Release any applicable information to my Primary Care Physician
____ Release medical information (e.g., diagnoses, medications, compliance, symptom ratings) only to my Primary Care Physician.
Primary Care Physician's Name, Address & Phone:
_____
_____
_____
_____ **DO NOT** release information to my Primary Care Physician

Insurer / Managed Care Company

_____ Release treatment plan information to_____ (Insurance/Managed Care Company) as required for authorization of treatment/payment

Please sign below:

_____ _____
(Patient or Patent's Guardian Signature) (Patient DOB)

_____ _____
(Print the name signed above) (Date)

CONSENT TO TREATMENT

Welcome to Room 2 Grow. As a new client, you should have received this consent handout as well as our Financial Policy, Patient Information Sheet, Authorization to Disclose Information to Primary Care and Insurer, Members' Rights and Responsibilities Statement and Notice of Privacy Practices. Please read them over carefully and if you have any questions or concerns about what you have read, please raise them with your therapist.

You can expect to be treated with respect and courtesy by all Room 2 Grow staff. We ask that you be an active participant in all decisions made concerning your care. It is important that all treatment goals and recommendations be mutually agreed upon. You do not have to allow the use of any particular technique or participate in any treatment assignment that you feel is inappropriate for you. During the course of treatment, we encourage you to talk with your therapist about how your therapy is progressing, and to voice any concerns directly with your provider.

Confidentiality and Communication with Others: Your rights as a client at Room 2 Grow include respect for your privacy and confidentiality of your treatment records. We will not acknowledge that you are a client with us or release any information about your treatment without written consent from you. However, there are very rare exceptions when we may be compelled by law to release information without your consent:

1. If you seriously threaten to harm another person, we must warn that person.
2. If we come in contact with a child and there is evidence to suggest he/she is a victim of abuse or neglect, we must notify the proper authorities.
3. If you say that you know of a child who is currently being abused, we must notify the proper authorities.
4. If you are 14 or older and you report that you have committed child abuse, even if the victim is no longer in danger, we must notify the proper authorities.
5. If you seriously threaten to harm yourself or have attempted to do so while in treatment, we will notify others to the extent necessary to secure your safety.
6. If a court orders us to testify about your treatment, we must comply.

At your initial session with us, you will be asked to sign a release of confidential information for your insurance company. Most insurance companies require us to provide your clinical diagnosis and additional information such as treatment plan or treatment summary in order to authorize payment for your sessions. You may refuse to allow us to release this information, however, your insurance company will most likely refuse to cover your services.

In addition, we will be asking if you will permit us to communicate with your primary care physician. This communication typically includes the following information: type and frequency of sessions and diagnosis. You may decline to allow us to communicate with your primary care physician and we will honor your request. However, in some cases this may have a detrimental effect on both your medical and behavioral health treatment.

Finally, we will be happy to hear any suggestions you might have about our policies regarding your treatment at Room 2 Grow. You can discuss these with your therapist.

I, _____, have read the consent handout, the Financial Policy, Patient Information Sheet, Authorization to Disclose Information to Primary Care and Insurer, Members' Rights and Responsibilities and Notice of Privacy Practices. I understand what I have read and I hereby give my consent for treatment.

_____ _____

Signature of patient or parent/guardian Date

Copy Accepted by Client: YES _____ NO _____