DO NOT COMPLETE THIS FORM UNTIL YOU HAVE A CONFIRMED APPOINTMENT.
AFTER COMPLETEING THIS FORM, YOU MUST BRING THE ORIGINAL IN TO YOUR FIRST APPOINTMENT.
FORMS SENT BY EMAIL OR FAX WILL NOT BE ACCEPTED.

Mental Health Resources, PC
(540) 899-9826 Fax (540) 373-3913

Patient Information Sheet

Date (or effective date of change) _____

Process: Insurance Y N Statement? Y N
*Referred By:*_____
Primary Care Physician: _____
*DSM IV:*_____ *Provider:* _____

Patient Information

Name: _____
last First middle

Address: _____
street city state zip code

Mailing Address: _____
(if different) street city state zip code

Home Phone: ( ) _____ **Work Phone:** ( ) _____ **Cell Phone:** ( ) _____

Ok to call? **Yes ☐ No ☐** **Yes ☐ No ☐** **Yes ☐ No ☐**

Ok to leave message? **Yes ☐ No ☐** **Yes ☐ No ☐** **Yes ☐ No ☐**

Date of Birth: _____ **Social Security # :** _____

Sex: ☐ **Male** ☐ **Female** **Marital Status:** ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Other**

Employer Name: _____ ☐ **FT** ☐ **PT** **Student** ☐ **FT** ☐ **PT**

Primary Insurance Information

Carrier Name: _____ Phone_____

Mental Health Claims Address: _____
street city state zip code

Group # _____ **Insured ID#**_____ **Is authorization required?**_____

Insured Name: _____ **Date of Birth** _____ **Sex:** ☐ **Male** ☐ **Female**

Insured Social Sec# _____ **Employer Name:** _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Workman's compensation related? Yes ☐ **No** ☐ **Claim file#** _____ **Injury date:** _____

Secondary Insurance Information

Carrier Name: _____ Phone_____

Mental Health Claims Address: _____
street city state zip code

Group # _____ **Insured ID#**_____ **Is authorization required?**_____

Insured Name: _____ **Date of Birth** _____ **Sex:** ☐ **Male** ☐ **Female**

Insured Social Sec# _____ **Employer Name:** _____

Patient relationship to insured: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other** _____

Person Responsible for Payment

Name: _____

Address: _____
street city state zip code

Home Phone: _____ **Work Phone:**_____ **Cell Phone:** _____

Date of Birth: _____ **SSN:** _____ **Sex:** ☐ **Male** ☐ **Female**

Employer: _____ ☐ **FT** ☐ **PT**

RELEASE AND ASSIGNMENT

I authorize the release of any medical or other information to any interested party in order to process my claim(s). I authorize and request payment of any medical benefits directly to my provider. I agree that this authorization will cover all medical services rendered until I personally revoke such authorization. I agree that a photocopy of this form may be used in lieu of the original. I understand that I am financially responsible for all charges incurred if denied by the insurance carrier (s).

Patient or Guardian Signature: _____ **Date:** _____

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AUTHORIZATION OF THE TREATMENT OF MINOR

I have legal custody or written authorization to direct treatment of this minor.

YES NO

If you do not have legal custody, please indicate what person or agency has custody. Please give the name of any case worker, etc.

_____

I,_____ am the parent or legal guardian of _____ . I have legal custody or hold valid written authorization to act on behalf of said minor.
I, authorize _____(therapist) to evaluate and perform appropriate psychological assessment and treatment and I assume all financial responsibilities regarding this minor.

I understand that evaluation, assessment and treatment may indicate a need for further parent/guardian sessions and/or family involvement. I also understand that the Therapist will utilize appropriate and acceptable treatment methods in keeping with code of ethics and guidelines of the American Psychological Association (APA).

I understand that this authorization for treatment may be revoked by me at any time should the need arise and that it is automatically revoked at the termination of treatment.

I understand that psychological testing may be performed by technical assistants. Technical assistants are trained in the administration and scoring of psychological testing. The treating clinician is responsible for all test interpretation and the contents of the final report. Some technical assistants are doctoral students in clinical psychology participating in externship programs. I understand that I can refuse the use of technical assistants in the evaluation but that this may require rescheduling to the evaluation appointment and delay in completion of the evaluation.

Technical assistants will not be used when not covered by your insurance.

DO NOT SIGN THIS IF YOU DO NOT UNDERSTAND IT, YOU MAY REQUEST AND EXPLANATION.

Signature: _____ Date: _____

Witness: _____ Date: _____

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations (Minor)

I _____ ,parent/legal guardian, of _____ understand that as part of my child's health care, Mental Health Resources, P.C. and the associated mental health providers originates and maintains paper and/or electronic records describing my child's health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my child's care and treatment;
- A means of communication among the mental health professionals who contribute to my child's care,
- A source of information for applying my child's diagnosis and mental health information to my child's bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a ***Notice of Information Practices*** that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Mental Health Resources, P.C. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations,

I further understand that Mental Health Resources, P.C. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Mental Health Resources, P.C. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).
I wish to have the following restrictions to the use or disclosure of my health information:

I understand that as part of this organization's treatment, payment, or health care operations, may become necessary: to, disclose my child's protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept /decline the terms of this consent. *(Please circle accept or decline)*

Parent/legal guardian's Signature _____ Date _____

FOR OFFICE USE ONLY

- ☐ Consent received by _____
- ☐ Consent refused by patient, and treatment refused as permitted,
- ☐ Consent added to the patient's medical record on _____

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FEES AND BILLING POLICY

Mental Health Resources, P.C. is an association of independent mental health professionals in individual private practice. The Responsible Party for this account is to provide complete and accurate information for billing and filing of insurance claims. It is the Responsible party's responsibility to provide the Administrative Office with any change in information, as soon as possible, and to complete any necessary forms.

PAYMENT is expected at the time services are rendered. This includes insurance deductibles, co-pays or the amount not covered by insurance. A monthly billing statement will be sent to you in regard to the status of the account and outstanding balance. The balance is due at the time the statement is received unless other financial arrangements have been made with the administrative office. Our office cannot legally enforce any court orders regarding payment collection for services. Therefore, you should expect to make complete restitution for all fees and charges on this account. If your account should become overpaid, a refund will be processed during the next quarter.

INSURANCE*; primary and secondary,* is billed by Mental Health Resources, P.C. as a courtesy to our clients. Insurance policies are contracts between you (or your employer) and the insurance company, therefore, it is your responsibility to understand your insurance policy requirements and limitations. Please take the time to verify your insurance benefits. We cannot guarantee payment of claims. Independent mental health professional chose individually which insurance carriers they wish to participate with. If the mental health professional associated with this account is a participating provider with your insurance carrier, the appropriate adjustment will be made to the account at the time an insurance payment is received. You are responsible for and expected to pay deductible, co-pay, insured portion for in network carriers, or for the difference between the amount that the out of network carrier pays and the amount of the charge. A copy of the insurance card is required and you are to supply all information necessary for our billing agent to file the insurance claim. Mental Health Resource, P.C. does not file claims for Court Ordered Evaluation.

PSYCHOLOGICAL EVALUATION or TESTING*:* the charges are based on the time spent administering and interpreting the test results, necessary and appropriate interviews and preparing a report, the total cost of the evaluation may not be known until the testing process has been completed. However, a payment on account towards the total charges is required on or before the date of service, before any testing can be administered.

Mental Health Resources, P.C. will process insurance claims as a courtesy in accord with our Fees and Billing Policy, however **Mental Health Resources, P.C. does not submit insurance claims for court ordered or court related evaluations**. If you require a Financial Agreement this should be negotiated prior to beginning the evaluation.

Mental Health Resource, P.C. policy for **Court Ordered or court related evaluation or testing** is a follows:
Before tests can be administered we should have in our possession:

1) Copy of the Court Order
2) **$850.00** payment per person being tested or
3) Letter from the attorney stating the attorney will pay for all testing charges and giving billing information; or
4) Letter from outside agency stating that they will pay for part or all of the testing charges. The Responsible Party agrees to pay for all charges not covered by this letter.

COURT APPEARANCE or TESTIMONY is billed at an hourly rate, portal to portal, plus mileage and expenses. A copying and file preparation charge will be billed for records or other materials subpoenaed. The individual requesting this activity must sign a separate agreement giving billing information prior to the independent mental health professional taking action on requests. This person will be billed separately from regular charges and payment is due in full upon receipt of statement.

NO SHOW or CANCELLATION of a scheduled appointment with less than 24 hours notice or may result in a No Show charge. This is at the discretion of your mental health provider. You are expected to pay this charge in the next billing cycle as insurance companies do not cover this charge. If you dispute a charge, please address it with your therapist.

RETURN CHECK A Charge of $25.00 (twenty-five dollars) will be applied to your account and the payment amount will be reversed on the account for any payments that are returned to us. In addition, we may require cash payment for all services rendered in the future.

DELINQUENT ACCOUNTS will be referred to an outside collection agency. Any fees or costs will be added to the account to cover the cost of collection and you will be responsible for these and any court costs incurred.

OFFICE CONDUCT The following conduct policies will be observed at all times.

- No Handguns or other weapons allowed on the property on Mental Health Resources, P.C. The only exception is law enforcement officers performing an act in the line of duty.
- No video and /or audio recording of a session without the prior written authorization of all parties involved
- Virginia law requires that therapist report suspected child abuse to a local department of social services within 24 hours of the discovery of a possible incident.

CHANGES *You are responsible to report any changes in insurance, address, phone numbers, and billing information in a timely manner . You will be responsible for any charges that are unpaid due failure to report such changes.*

ALL INSURANCE CARRIERS ARE CONTACTED FOR ELIGIBILITY, BENEFITS AND AUTHORIZATIONS FOR ALL SERVICES RENDERED. HOWEVER, PER ALL INSURANCE CARRIERS DISCLOSURE, THIS IS NOT A GUARANTEE OF PAYMENT UNTIL CLAIMS ARE SUBMITTED AND PROCESSED. PATIENTS WILL BE RESPONSIBLE FOR ANY AND ALL NON-COVERED CHARGES.

Please Print Information

Patient Name: _____ Responsible Party: _____

I, _____, as the Responsible Party for this account

have read and understand this policy.

Signature: _____ Date: _____

PATIENT PAST MEDICAL HISTORY
(MINOR)

Has your child been seen by any other mental health care provider/therapist in the last 5 years? Yes No
If "yes", please provide their name, address and phone number: _____
_____
_____

Is your child currently taking any medication(s)? Yes No
If "yes", please list the medication(s): _____
_____
_____

Does your child have a primary care physician? Yes No
If "yes", please provide their name, address and phone number: _____
_____
_____

What is the date of your child's last physical exam? _____

Has your child ever used illegal drugs? Yes No
If "yes", please list what kind and for how long they have used: _____
_____
_____

Does he/she drink alcohol? Yes No How much and how often: _____

Does he/she smoke? Yes No How much and how often: _____

Has your child ever had suicidal thoughts? Yes No
Has your child ever attempted suicide? Yes No If "yes", please give the date(s):_____

Does your child or any of their family members have a history of mental disorders? Yes No
If "yes", please list their name(s) and type of mental disorder: _____
_____
_____

Has your child had any type of surgery which may be relevant to their mental health? Yes No
If "yes", please provide the type and the date of the surgery: _____
_____
_____

How much have the following problems bothered your child in the last 6 months?

	Not at All	A Little	Somewhat	A Lot
Nervousness or shakiness	_____	_____	_____	_____
Feeling sad or blue	_____	_____	_____	_____
Feeling hopeless about the future	_____	_____	_____	_____
Feeling everything is an effort	_____	_____	_____	_____
Feeling no interest in things	_____	_____	_____	_____
Your heart pounding or racing	_____	_____	_____	_____
Trouble sleeping	_____	_____	_____	_____
Feeling fearful or afraid	_____	_____	_____	_____
Difficulty at home	_____	_____	_____	_____
Difficulty socially	_____	_____	_____	_____
Difficulty at work or school	_____	_____	_____	_____

Will you need to have any of your child's mental health information released to their primary care physician and/or another medical provider? Yes No

If "yes", please be sure to sign a "Release of Information" form with our front office staff.

Print:

_____

Patient Name

_____

Parent/Legal Guardian

_____

Date

Signature:

_____

Patient Name

_____

Parent/Legal Guardian

FOR OFFICE USE ONLY

Release of Information received by: _____

Release of Information added to patient's medical record on: _____

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PLEASE READ AND COMPLETE

Dear Patient or Legal Guardian,

Effective April 15, 2003, new Federal regulations will require all doctor's offices to identify callers before giving out any health information. This includes appointment time information, either the: scheduling, confirming, changing or canceling of scheduled appointments. To make this easier to Implement, Mental Health Resources Is asking all of our patients or Legal Guardian to complete and sign this form so that we can assemble the necessary information.

When you call In the future to make or change an appointment, you will be asked to provide:

- Your Name
- Patient's Name
- Patient's date of birth or Optional Pass Code
- The last four (4) digits of the patient's social security-number or Optional Pass Code
- Name of therapist the patient is seeing.

In addition we are asking you to provide the name of any persons, such as a spouse, that you wish to authorize to make, change or cancel appointments. Use the "Special Concerns" section to list any special concerns that you have about telephone exchanges of information.

Mental Health Resources is offering an alternative of a Pass Code. You may set up a password. Please choose a word that you will easily remember but will be special to you and other people won't know. Please write down or remember your pass code. Pass codes are optional.

We regret any inconvenience caused by this newly required system.

Telephone Confirmation of Information Form

Patient's Name: _____

Patient's date of birth: _____

Last four digits of Patient's Social Security Number: _____

Legal Guardian: _____

Persons other than patient / legal guardian authorized to change appointments:

_____

_____

Special Concerns: _____

_____

Signature:_____ Date: _____