WELCOME TO ROSE STREET MENTAL HEALTH CARE
1800 Rose St, Wichita Falls, Tx 76301
940-723-4488

_____ has an Initial appointment with:

- ☐ David Sabine, PhD
- ☐ Arthur Cardona, PsyD
- ☐ Katie Lister, PMHNP-BC
- ☐ Shelli Craig, PMHNP-BC
- ☐ Cat Quinn, LPC
- ☐ Staci Koetter, LPC

_____ at _____ am ☐ pm ☐

The patient must bring **PROOF OF INSURANCE** to this appointment. If you do not have proof of insurance or cannot pay the Initial fee out of pocket, your appointment will be rescheduled.

Please have **all paper worked filled out completely** before your appointment. If the paperwork is not complete, your appointment may be rescheduled.

If it is necessary to cancel or reschedule this appointment, please do so 24 hours in advance or a charge of $25 may be charged. If you have any questions, please call the office.

Primary Care Provider

Patient Name: _____

Who is the primary care provider (PCP) for the patient? _____

Phone Number: _____

Address:_____

_____

Were labs requested by your PCP within the last 6 months? ☐ Y ☐ N

If so, when and where did you go?

_____

Do you have a copy of the results you can give us to put in your medical record? ☐ Y ☐ N

Some insurances require labs to be drawn every six months to a year in order to continue your medication(s). If it has been more than six months, depending on your insurance, we will send a lab slip with you to get them done by your next appointment. If you have any questions, please contact the front desk.

Patient Information

Name: _____

Address: _____ Phone: _____

_____ _____

_____ Email: _____

PLEASE CIRCLE ONE: ☐ current smoker ☐ former smoker ☐ never a smoker

Marital status: ☐ married ☐ divorced ☐ widowed ☐ single

Please check if there is a **DIAGNOSED** history within your close family (mother, father, brother, sister, son or daughter) of any of the following. If there is a positive history, please specify which family member(s).

☐ Anorexia/Bulimia/Eating disorder	_____
☐ Anxiety disorder	_____
☐ Autism	_____
☐ Bipolar	_____
☐ Dementia/Amnesia	_____
☐ Depression	_____
☐ Attention Deficit Disorder	_____
☐ Drug Abuse/Dependence	_____
☐ Hypochondria	_____
☐ Multiple Personality Disorder	_____
☐ Narcolepsy	_____
☐ OCD	_____
☐ PTSD	_____
☐ Schizophrenia/Psychotic Disorder	_____
☐ Other mental health issue	_____

Drug Allergies: _____

Please list your current prescribed medications, including OTC medications and vitamins/minerals

Medication	Dose	Frequency

Your Information, Your Rights, Our Responsibilities

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you:

- You can ask to see or get an electronic or paper copy of your medical records and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee
- You can ask us to correct health information about you that you think is incorrect or incomplete. We may say "no" to your request, depending on what you want corrected, and we will tell you why in writing within 60 days
- Please let us know if you have a different contact number other than the one given. or you need to be contacted in another way such as email or a different mailing address
- We will do our best to be accomodating with any request you have of us
- You can ask us **NOT** to use or share certain health information for treatment. However, please understand there are some cases when we would have to deny your request and must abide by the law
- You can ask for a list of the times we have shared your health information for up to six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures
- If you have legally assigned a medical power of attorney or a legal guardian, that person can exercise your rights and make choices about your health information. This person has the authority to act for you until you deem it unnecessary.

Complaints:

- If you feel your rights have been violated by any member of the clinic, please make complaints or voice concerns by contacting us using the information on the back page.
- You also can file a complaint with the US Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W. Washington, DC 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices:

For certain health information, you can tell us your choices about what we share and to whom. If you have a clear preference for how we share your information in the situations described below, please let us know in writing. We will abide by your wishes

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

In the instance you are unable to speak due to an accident or medical issue, it may be necessary for us to share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to your health or safety.

We will never share your information unless you give us written permission for the following:

- Marketing purposes
- Sale of your information

Other Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways:

- We can use your health information and share it with other professionals who are treating you.
    - Example: a doctor treating you for an injury asks another doctor about your overall health condition.

- We can use and share your health information with other providers you may see at the clinic to improve your care
    - Example: we use health information about you to manage your treatment and services.

- We can use and share your health information to bill and get payment from health plans or other entities.
    - Example: we give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are required to share your information in ways that contribute to the public good, such as public health and research. They have to meet several conditions in the law before we can share your information for these purposes, for more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- We can share health information about you for certain situations such as:
    - Preventing disease
    - Helping with product recalls
    - Reporting adverse reactions to medications
    - Reporting suspected abuse, neglect, or domestic violence
    - Preventing or reducing a serious threat to anyone's health or safety

- We can use or share your information for health research
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we are complying with federal privacy law.
- We can share health information about you with organ procurement organizations.
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies
- We can use or share health information about you
    - For workers' compensation claims

- For law enforcement purposes or with law enforcement officials
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information, other than as described here, unless you give permission in writing to do so. You also are free to retract the permission given by letting us know in writing
-

For more information see www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Changes to the Terms of This Notice

If there are any changes or updates, we will make you aware. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices allies to the following organizations:

Rose Street Clinic
Rose Street Spectrum

Acknowledgment of Receipt of Notice of Privacy Practices

Please sign and date here stating you have received, read and understand the Notice of Privacy Practices.

_____ _____

Signature Date

If you would like to list anyone who you would like to be authorized to call about your care, make appointments for you, or speak on your behalf, please list below with phone number or password that you assign so we know it is the person you assigned. If they call, we will require them to either give us the phone number you listed for them or tell us the password. If they cannot give either, we will not release any information to them unless you call to give us verbal permission. Your privacy is our number one priority in protecting you

_____ _____

_____ _____

_____ _____

Appointment Reminders (please list the phone numbers we can call/text for appointment reminders):

Phone:_____ Text:_____

Confidentiality and Records

Information you disclose during the course of seeing a mental health professional will be kept in the strictest of confidence. Such information will not be shared with others without your written consent and permission. Under Texas law, there are exceptions: If you or another is at risk of serious harm, if there is a suspicion of child abuse, in legal actions against children or between parent children, and for non-payment of fees. A record may be shared with other professionals at RSMHC, LLP without a release if those professionals become part of the patient's treatment process. If you would like another professional to obtain a copy of your record, a written release of information must be signed. Any fees for records must be paid by the requesting party in advance of receipt of records. There will be a charge for completion of forms or reports for someone other than your insurance carrier. Please check with office staff if you have questions about fees for your records or forms.

Cancellations and Missed Appointments

If you need to reschedule your appointment, we ask you to contact our office within 24 hours prior to your scheduled appointment. An appointment, which is missed without notification is considered to be a "no show". Notification to your referring physician or agency will be made if you miss your appointment without contacting our office. **If you "no show" two consecutive scheduled Initial appointments, we will assume you no longer want our services, and your account will be closed.** If you desire to return to treatment, you will need to discuss this directly with your provider before an appointment can be scheduled.

Insurance and Billing Information

We are required to have copies of insurance cards and current Medicaid eligibility. If a patient fails to have proof of insurance at the time of the appointment, we have the right to cancel and reschedule your appointment or the patient will be considered "self-pay" and will need to pay upfront before services are rendered. **PAYMENT IS EXPECTED AT THE TIME OF SERVICES**. We do accept all major credit cards, personal checks, money orders, cashier's checks, and cash. There will be a $25.00 charge for any returned checks. Due to confidentiality concerns we are unable to talk to any person besides the guarantor/patient regarding their bill. Unpaid account balances outstanding for more than 45 days may be referred to a collection agency, small claims court, or other legal means for collection. The patient is responsible for any collections, court, or attorney fees from such referral

Prescriptions

Requests for prescriptions are to be called in **24 to 48 hours ahead of time**, Monday through Friday for approval. We will only contact you if we have questions regarding your refill request. Due to our high patient volume, we are unable to call each patient to let them know their electronic prescription has been sent. However, if your pharmacy states they have not received your prescription request electronically after 48 hours please call us so we can research why it was not transmitted. For any handwritten prescriptions, there will be a $5.00 charge for reissue of expired or lost prescriptions.

I have received and read this document and give my consent for evaluation and treatment. I understand there are both potential benefits and risk to treatment and I can discuss these with a clinician at any time. I authorize the release of medical information and processing my insurance claim and assign payment of benefits by my insurance company to RSMHC, LLP. I understand that I need to notify RSMHC, LLP staff of changes to address, phone numbers or insurance information. I understand that in case of an emergency I can contact RSMHC, LLP. However, in the event, that a clinician cannot be reached, local emergency rooms are available to provide emergency services.

Patient (printed)name _____ Date _____

Signature _____ Relationship to Patient _____

INSURANCE INFORMATION FORM

Patient Name:_____

Policy Holder Information

Name:_____ Relation to patient:_____

SSN:_____ DOB:_____

INSURANCE INFORMATION

Primary Insurance:_____ Name of Insured:_____

ID#_____ Group#_____

Relation to Patient:_____ DOB:_____

Secondary Insurance:_____ Name of Insured:_____

ID#_____ Group#_____

Relation to Patient:_____ DOB:_____

If you have a tertiary (third) insurance, please write in on this page or let us know at time of appointment

Account Responsible

Name:_____ Phone:_____

DOB:_____ SS#:_____

Address:_____

Relationship to Patient_____

Patients with Health Insurance

(PLEASE READ THIS, WE REALIZE THERE IS A LOT OF INFORMATION BUT IT IS VERY IMPORTANT)

1. We will not balance bill you whether you had services from our outpatient clinic or from our doctors that did rounds (doctor fees are separate from facility) while you were inpatient at Red River Hospital, Red River Recovery or Pathways. We accept assignment on all claims. This means we will not try to collect any money above what your insurance allows for the charge. When we collect money from you it is because **your insurance** has informed us that we are to collect the copay, deductible and/or coinsurance amount from you. This is the amount your insurance allows but does not pay. If you have any questions about these fees, please contact our front office before your visit or contact your insurance company. It is your insurance that has set these collection amounts that we ask for you to pay
2. There may be a time your insurance gives us incorrect benefits. We are sorry to say, since we are a specialty to most insurances, this happens more often than we would like lately. Since all private insurances have different benefits for different groups it is sometimes difficult to know whether the benefits are correct or not until we receive an EOB. If you receive a bill after the fact of your insurance processing the claim, there will be an explanation as to the reason you are receiving it
3. Please feel free to contact our business office if you have billing questions, need copies of the insurance EOB (Explanation of Benefits), or an itemized statement showing all charges and how they were processed. We will gladly send you whatever you need, so you can better understand the bill, or if you need the statement in case you need to contact your insurance with any questions you may have. We keep copies of everything for several years onsite
4. If you were seen outside of the clinic at an inpatient facility like Red River Hospital, Red River Recovery or Pathways, where our doctors do rounds, you should have been told by that facility that the **facility charges and doctor charges are separate**. Our doctors are not employees of these outside facilities. If you have been told doctor charges are all inclusive to the facility, by them or by your insurance company, then the facility should be sending the doctor payment to us. Let us know if you receive a bill from us by mistake due to this and we will contact your insurance and the facility and have this corrected.
5. For inpatient doctor charges, if you receive a bill from us for inpatient services for the doctor charges this means charges have processed and you are receiving a bill from us for your coinsurance, deductible, and copays that your insurance has stated you owe. If you do not agree with what your insurance states you owe, feel free to contact our business office and they will call your insurance to discuss the way they processed the claims, or you also can contact your insurance company to discuss the charges.
6. If you make a payment arrangement with us, to pay a certain amount every month, and do not follow through with the agreement then your account may be turned over to outside collections immediately. Also, all appointments will be cancelled until you pay, and your medication refills may be stopped as well.
7. It is a violation of your insurance contract that you signed with them if you do not pay for your coinsurance, copay, and deductible. We are also violating the terms of our contract with your insurance if we do not collect the necessary fees set forth by them. We can be terminated from the insurance contract if we do not collect from you, and if we are terminated, we can no longer see you as a patient since we will not be covered providers under your insurance.

Overview

- There will be a charge of $50 for no show appointments, this is because had you called us to cancel the appointment, we could have scheduled someone else to be seen in your place and the provider would not have a wasted hour
- Appointments must be cancelled within 24 hours of your appointment, failure to do so will result in a charge of $25
- There will be a charge for the completion of forms or dictation of letters, the provider sets this fee
- Insurance benefits will be called on before your appointment. If you are not eligible for coverage, you will be responsible for payment of the charge for your appointment. If you have a new insurance, please alert us immediately so benefits can be called on. If you do not you will be responsible for the charge amount and once your new insurance processes the claim you will be refunded if there is an overpayment amount
- Copay's/Deductibles/Coinsurance payments are due at the time of your appointment
- If you are a Medicaid patient and you no show or fail to cancel within 24 hours of your appointments more than two times in a year at your provider's discretion you will not be rescheduled with Rose Street Mental Health Care

If you have any questions, please ask the front desk staff or your clinician.

I have read and understand the above statement.

_____

Signature

Rose Street Mental Health Care

I authorize Rose Street Mental Health Care to contact me via current and any future cellular phone number(s), email address(es), or wireless device(s) regarding information I need or if I have a delinquent account(s) where I owe money to Rose Street Mental Health Care. I also authorize its agents, collection agency and attorneys to use automated telephone dialing equipment and artificial/pre-recorded voice messages and personal calls, in their effort to contact me for purposes of collecting any portions of my account which is past due.

I/We have read this disclosure and agree to the terms described above.

_____ _____

Patient or Account Responsible Signature Date

_____ _____

RSMHC Agent Signature Date