Rocky Mountain Psychiatry

Kenneth D. Krause, M.D.
Vicki L. Grossman, APRN, PhD

****<u>Please complete all questions on this form</u>****

Date: _______________________

<u>PATIENT INFORMATION</u>:

Patient Name: ____

Address: ____
City State Zip

Home Phone: __________________ Cell Phone: __________________

Work Phone: ___________________

E-Mail Address: ____

OK to contact at home: Yes No | OK to leave message at home: Yes No

OK to contact at cell: Yes No | OK to leave message at cell: Yes No

OK to contact at work: Yes No | OK to leave message at work: Yes No

Date of Birth: ____________________ Age: _________

Marital Status: ___________________ Gender: Male _____ Female _____

Employer: _______________________ Occupation: ___________________________

How were you referred to our office?____

<u>EMERGENCY CONTACT</u>:

Name: ____

Phone: _________________ Relationship: ___________________

May we leave a message? Yes No

<u>RESPONSIBLE PARTY:</u> (If different from patient)

Name: ____________________________________ Phone: ______________________

Address: ____
City State Zip

<u>PRIMARY CARE PHYSICIAN:</u>

PCP Name: _______________________ Phone: ___________________

May we communicate with your PCP? Yes No ________ (if "No", please initial)

<u>INSURANCE INFORMATION:</u> Why do we ask for the *<u>primary insured's</u>* personal information? Many insurance companies subcontract their mental health and substance abuse benefits out to other companies. Consequently, these subcontractors do not store benefit information using the same ID # on your card. The primary insured's information may be required to check benefits, obtain authorizations and for claim submission. Please be assured that we will keep this information confidential and is only used when necessary for insurance purposes.

Insurance Company/HMO: ___________________________ Phone: _______________

ID # _________________________ Group # __________________

Name of Primary Insured: _____________________

Primary Insured Employer: ____

Primary Insured DOB: _______

<u>IS CONDITION RELATED TO:</u>

Employment: Yes No Accident: Yes No

If yes, claim number: _______________________________

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NO SHOW POLICY AND PROCEDURE

All no show appointments or appointments cancelled without giving 24 hours notice will be subject to a no-show fee. These fees are equivalent to the entire cost of the appointment you had scheduled (between $60-$120, depending on appointment time allotted). If appointment is cancelled at least 6 hours before appointment, these fees may be reduced. These fees CANNOT be billed to insurance. **You will no longer be able to schedule a follow-up appointment without first paying this fee.**

Poor road conditions, illness, car troubles, and any other emergencies that may come up will be at the discretion of the office and may still result in a fee. Proof may be requested to avoid a no-show fee.

If you feel that poor driving conditions may prevent you from getting to the office for your appointment, we ask that you call to cancel your appointment at least 24 hours in advance. Our policy is that if the office is open, we expect people to keep their appointments. Planning ahead is necessary and most weather conditions are reported with enough time to cancel appointments.

Three no-show appointments with Rocky Mountain Psychiatry will result in termination of our professional relationship. Without proper follow-up we cannot continue to provide appropriate care.

Please let us know if you have questions or concerns.

LATE ARRIVAL POLICY

We at Rocky Mountain Psychiatry make every effort to be on time, but regrettably there are times when we are behind schedule. We also understand that unforeseen events do occur that cause people to be late for their appointments. Every attempt will be made to see patients who arrive late for their appointments; however if you are late by 10 minutes or more for your appointment you may be asked to reschedule. Due to very tight schedules, it is often not possible to accommodate late arrivals. You may wait for cancellations or see if you can be "squeezed in", but this cannot be guaranteed. It is at the discretion of Rocky Mountain Psychiatry whether you will be charged for a missed appointment. We hope that this will allow for an improved patient flow and visit experience with Rocky Mountain Psychiatry. Should you have any questions or concerns regarding this policy please discuss them with your provider prior to signing below that you understand our policy.

____________________________________ ________________
Name Date

2600 S. Parker Rd. · Building 4, Suite 242 · Aurora, CO 80014
(303)750-2082 phone · (303)750-6313 fax

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Financial Policy for Rocky Mountain Psychiatry

1. The office will bill insurance for you if you provide an insurance card. We accept assignment on all plans to which we belong. You owe deductibles, co-payments and non-covered charges at the time of service.
2. You are responsible for obtaining the initial authorization from the insurance company, if required. (Please keep in mind that many PPO policies also require prior authorization for mental health and substance abuse services.) We will get *follow-up* authorization for your visits.
3. Self pay patients will be billed at $180 for the initial appointment, $80 for 20 minute appointments and $120 for 30-40 minute appointments
4. You will be billed for missed appointments at the full fee without 24-hour notice or an illness/emergency situation that prevents notification.
5. The following services are not covered by insurance and will be billed at a rate of $20.00 for the first 5 (five) minutes and $15.00 for each additional 5 (five) minutes.
    1. Letters to employers, insurance companies, lawyers and other third parties except physicians and therapists.
    2. Dictated reports.
    3. Completion of forms including, but not limited to, FMLA and disability.
    4. Phone calls for therapy, consultation or medication management that are not emergencies.
    5. Phone calls after 5:00 P.M. or on weekends that are not emergencies, including all medication refills.
    6. Phone calls to lawyers, employers, disability insurances and case managers. Calls to physicians and therapists are not charged.
    7. Phone calls to get pre-authorization for medication. We will attempt to prescribe medication covered by your insurance plan. However, we are unable to keep track of the formularies for all plans.
6. Medical records sent to third parties except physicians and therapists will be billed based on the number of pages.
7. If finances are a problem, we will be flexible about arranging a payment plan. Please let us know.

______________________________ ____________
Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED, DISCLOSED, AND SAFEGUARDED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses treatments, and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

- Maintain the privacy of your health information as required by law;
- Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
- Follow the terms of our Notice currently in effect.

II. Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Privacy Officer
2600 S. Parker Road, #242
Aurora, CO 80014
(303) 750-2082

III. Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association's Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information. Participants in this organized health care arrangement also share health information with each other, as necessary to carry out treatment, payment, or health care operations relating to the organized health care arrangement.

Example of using or disclosing health information for treatment:

- A nurse takes your pulse and blood pressure, records it in the medical record, and informs your doctor of the results.

Example of using or disclosing health information for payment:

- We submit a bill to your health insurer to receive payment for your care; the insurer asks for health information (for example, your diagnosis and what care we provided) in order to pay us. In such situations, we will disclose only the minimum amount of information necessary for this purpose:

Example of using or disclosing health information for health care operations:

- In the course of providing treatment to patients, we perform certain important functions such as quality assessment, training programs, credentialing, medical review, etc. In performing such functions, we may rely on certain business associates to assist us. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

IV. Other Uses and Disclosures

Clinical judgment, state law, professional practice/ethical standards must be considered for the following uses/disclosures.

In addition to uses and disclosures related to treatment, payment, and health care operations, we may also use and disclose your personal information without authorization for the following additional purposes:

Abuse, Neglect, or Domestic Violence

- As required by law, we may disclose health information about you to a state or federal agency to report suspected abuse, neglect, or domestic violence. If such a report is optional, we will use our professional judgment in deciding whether or not to make such a report. If feasible, we will inform you promptly that we have made such a disclosure.

Appointment Reminders and Other Health Services

- We may use or disclose your health information to remind you about appointments or to inform you about treatment alternatives or other health-related benefits and services that may be of interest to you, such as case management or care coordination.

Business Associates

- We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to service and maintain our computer systems, or to do our billing. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us.

Communicable Diseases

- To the extent authorized by law, we may disclose information to a person who may have been exposed to a communicable disease or who is otherwise at risk of spreading a disease or condition.

Communications with Family and Friends

- We may disclose information about you to persons who are involved in your care or payment for your care, such as family members, relatives, or close personal friends. Any such disclosure will be limited to information directly related to the person's involvement in your care.

- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Coroners, Medical Examiners, and Funeral Directors

- We may disclose health information bout you to a coroner or medical examiner, for example, to assist in the identification of a decedent or determining cause of death. We may also disclose health information to funeral directors to enable them to carry out their duties.

Disaster Relief

- We may disclose health information about you to government entities or private organizations (such as the Red Cross) to assist in disaster relief efforts.

- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated, we will use our professional judgment to determine what is in your best interest and whether a disclosure may be necessary to ensure an adequate response to the emergency circumstances.

Facility Directories

- If you are receiving inpatient care, we may include in our facility directory certain information about you, including your name, your location in our facility, your condition in general terms (for example, "critical" or "fair"), and your religious affiliation. Directory information about you is available to members of the clergy, and (excluding information about your religious affiliation) to visitors who ask for you by name.

- If you object to having some or all of this information about you included in our facility directory, let us know, and we will refrain from dong so. If emergency circumstances prevent us from asking you about the directory, we will use our professional judgment to determine what is in your best interest until there is a reasonable opportunity for you to object.

Food and Drug Administration (FDA)

- We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.

Fundraising

- As part of our fundraising efforts, we may use, or disclose to a business associate or institutionally related foundation, demographic information about you and information regarding your dates of care. Any fundraising materials that you may receive will tell you how you can opt out of receiving any further fundraising communications from us.

Health Oversight

- We disclose health information about you for oversight activities authorized by law or to an authorized health oversight agency to facilitate auditing, inspection, or investigation related to our provision of health care, or to the health care system.

Judicial or Administrative Proceedings

- We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations.

Law Enforcement

- We may disclose health information about you to a law enforcement official for certain law enforcement purposes. For example, we may report certain types of injuries as required by law, assist law enforcement to locate someone such as a fugitive or material witness, or make a report concerning a crime or suspected criminal conduct.

Minors

- If you are an unemancipated minor under Colorado law, there may be circumstances in which we disclose health information about you to a parent, guardian, or other person acting *in loco parentis*, in accordance with our legal and ethical responsibilities.

Notification
- We may notify a family member, your personal representative, or other person responsible for your care, of your location, general condition, or death.

- If you are available, we will provide you an opportunity to object before disclosing any such information. If you are unavailable because, for example, you are incapacitated or because of some other emergency circumstance, we will use our professional judgment to determine what is in your best interest regarding any such disclosure.

Organ and Tissue Donation
- We may discuss health information about you to organ procurement organizations or similar entities to facilitate organ, eye, or tissue donation and transplantation.

Parents
- If you are a parent of an unemancipated minor, and we are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances. For example, if we are legally required to obtain your consent as your child's personal representative in order for your child to receive care from us, we may disclose health information about your child to you.

- In some circumstances, we may not disclose health information about an unemancipated minor to you. For example, if our child is legally authorized to consent to treatment (without separate consent from you), consents to such treatment, and does not request that you be treated as his or her personal representative, we may not disclose health information about your child to you without your child's written authorization.

Personal Representative
- If you are an adult or emancipated minor, we may disclose health information about you to a personal representative authorized to act on your behalf in making decisions about your health care.

Public Health Activities
- As required or permitted by law, we may disclose health information about you to a public health authority, for example, to report disease, injury, or vital events such as death.

Public Safety
- Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement.

Required by Law
- We may disclose health information about you as required by federal, state, or other applicable law.

Research
- We may disclose health information about you for research purposes in accordance with our legal obligations. For example, we may disclose health information without written authorization if an Institutional Review Board (IRB) or authorized privacy board has reviewed the research project and determined that the information is necessary for the research and will be adequately safeguarded.

Specialized Government Functions
- We may disclose health information about you for certain specialized government functions, as authorized by law. Among these functions are the following: military command; determination of veterans benefits; national security and intelligence activities; protection of the President and other officials; and the health, safety, and security of correctional institutions.

Workers' Compensation
- We may disclose information about you for the purposes related to workers' compensation, as required and authorized by law.

V. Your Health Information Rights
Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

- Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.

- Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a post office box. We will accommodate reasonable requests for such confidential communications.

- Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.

- Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.

- Request a list of our disclosures of your health information. This list, known as an "accounting" of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge. However, if you request more than one accounting in any 12-month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested. We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years.

- Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section II above for information). If you have questions about your rights, please speak with our contact person, available in person or by phone during normal office hours.

VI. **To Request Information or File a Complaint**

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to our contact person (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHHH Building, Washington D.C. 20201; by calling 1-800-368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint with HHS as a condition of receiving care from us, or penalize you for filing a complaint with HHS.

VII. **Revisions to This Notice**

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our office, [and] make copies available to our patients and others, [and post it on our website].

VIII. **Effective Date**:

February 15, 2006

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Patient's Acknowledgement of Receipt of Notice of Privacy Practice

Patient's Name: ______________________________________ Birth Date: ____________

Maiden or other name (if applicable):____

I acknowledge that I have received a copy of the Notice of Privacy Practices, effective February 15, 2006.

Signature:____
(Patient or authorized representative)

Date:__________________________

Relationship if signed by authorized representative:___________

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Policies and Procedures

Treatment Philosophy

Treatment involves an open dialogue between the patient and the psychiatrist in an emotionally safe environment. Our goal is to provide help in a way that is caring, effective and efficient. To this end we will work together to set and achieve your treatment goals.

Limit of Confidentiality Statement

All information between psychiatrist and patient is kept confidential. There are legal exceptions to this:

1.) The patient authorizes release of information with a signature.
2.) A court orders release of records.
3.) The patient presents as a danger to self.
4.) The patient presents as a danger to others.
5.) Child and Elder abuse and/or neglect are suspected.

In some cases, the psychiatrist is required by law to inform potential victims and legal authorities so that protective measures can be taken.

Release of Information

I authorize the release of information for claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan.

Initial Here:________

Medication Refills

Prescriptions will ordinarily be written to cover the time between appointments. If refills are needed, please have your pharmacy call the office for approval. Please plan ahead as refills are not available on weekends or holidays.

Initial Here:________

Financial Terms: Insurance Coverage and Co-payments

You are responsible for obtaining the initial authorization for treatment from your insurance carrier. We will bill your insurance; however, you are responsible for paying co-payment amounts and deductibles as set by your benefit plan at the time of service.

Initial Here:________

Non-Covered Charges

Charges for services which are not benefits of the insurance plan are the patient's responsibility. The following services not generally covered by insurance plans and will be billed at a rate of $20 for the first five minutes and $15 for each additional five minutes:

-Telephone calls or emails to a patient for consultation or medical management

-Intervention for medical management purposes on a patient's behalf with agencies, employers or insurance companies, including preauthorization for non-formulary medications.

-Psychiatric evaluation of records, reports, or other date for medical management purposes.

-Discussions, explanations, and advice to family or other responsible persons including attorneys, employers, insurance companies and case managers. Calls to physicians and therapists are not charged.

-Preparation of reports and completion of forms for employers, agencies, insurance carriers, or attorneys

Initial Here: ________

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Cancellation and Missed Appointment Policy

Scheduled appointment times are reserved especially for you. If an appointment is missed or canceled with less than 24 hours notice, you will be billed unless an illness/emergency prevents notification. Your insurance company will not be billed for fees associated with missed appointments or late cancellations.

Initial Here: ________

Informed Consent for Medication and Treatment

I consent to participate in the mental health evaluation and treatment process. I understand that medication management involves an ongoing discussion between the patient and the provider. Relevant subjects for discussion in medication management include side effects, drug interactions, effects on pregnancy or breast feeding, risk factors, expected benefits, and prescriptions of medication for non-FDA approved uses. I will notify my provider if I plan to become pregnant or find I am pregnant while on medication.

Initial Here: ________

Rights and Responsibilities

Rights	Responsibilities
Respect and Dignity	Treat provider and staff with dignity and respect
Fair non-discriminatory treatment	Give provider the information he/she needs to give care
Timely care	Ask questions about treatment
Knowledge of treatment choices/options	Follow the treatment plan
Involvement in treatment planning	Inform provider about other medical conditions and treatment
Explanation of medical condition	Keep appointments
Choice of provider	Be on time for appointments
Qualifications of provider	Inform provider if treatment plan is not working
Filing complaints	Inform provider about problems paying fees
Information about managed care company	Report abuse, fraud, or quality of care concerns
Giving input into office policies	

Initial Here: ________

____

Patient/Guardian Signature Date

Rocky Mountain Psychiatry

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CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: ____ **DOB:** _________________

By initialing the information items I approve, I authorize release of the following medical information to the **Health Care Practitioner and verbal communication with the practitioner:**
(Check and initial all that apply)

Mental Health Diagnosis ______
Medication Management Information ______
Mental Health Treatment Records ______
Other information___________________________________
Substance Abuse (SA) Information ______
Discussion with Provider_______

Initial if you do not want information sent to your primary care provider or therapist: ---------------

I do____ I **do not**____ want records received from other healthcare providers included in this request. (If neither box is checked those records will be provided if the request is for all records.)

_________________________________ _____________________ ____________________
Primary Care Provider Phone Number Fax Number

____
Address City State Zip

_________________________________ _____________________ ____________________
Therapist Phone Number Fax Number

____
Address City State Zip

_________________________________ _____________________ ____________________
Name Phone Number Fax Number

____
Address City State Zip

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance hereon. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to the authorized recipient(s) only. Additional information may be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon request. I may inspect or copy the health information to be used or disclosed. Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

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Signature of Patient or Legal Guardian Date

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