Tri-Rivers Healthcare, PLLC

BEHAVIORAL HEALTH NEW PATIENT PACKET

Please review the treatment agreement, complete all questionnaires, sign and date the documents.

What you can expect for at your first visit:

1. You may be asked to complete some information regarding your history and current information as to why care is requested.
2. If the patient is a minor, a legal guardian must accompany them to the first session. (Legal guardian will not attend session but will need to be available in case clinician needs to speak with them)
3. We ask if there is a custody agreement, that we have a copy of the court documents for clarification for the client's chart.
4. Please bring a list of all current medications and supplements.

If you receive medications as part of your treatment:

1. It is your responsibility to inform your provider of any refill needs during your appointment.
2. For stimulants, please call the office at least one week before your next refill is due. Some providers have limited office hours.
3. You must have a recent appointment to receive any refills.
4. If you lose your prescription please call the office, it will be left up to your provider as to whether to refill or not, state and federal law may not allow for another prescription to be written. Please keep your medications in a safe place.
5. If you suspect your medication has been stolen, please file a police report. You will need to submit a copy of the report and your provider will determine if another prescription can be written.
6. If you have questions about your medications prior to your next appointment, please feel free to call the office. If you reach the nurse's voicemail, please leave; name, date of birth, provider, etc. Please allow some time for a response based on providers schedule.

IF AT ANY TIME YOU ARE EXPERIENCING AN EMERGENCY,

PLEASE CALL 911 OR GO TO THE LOCAL EMERGENCY DEPARTMENT

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Privacy:

Our clinic is committed to following HIPAA guidelines and we strive to achieve the highest standards of ethics and integrity in performing services.

A copy of the full HIPAA law is available upon request. If you ever have a concern, please contact our Operations Manager at 270-988-3298.

The Health Insurance Portability and Accountability Act (HIPAA) provides you with rights regarding your clinical records and disclosure of health information. These rights allow you to authorize how your medical record and health information is released to you or others. If the client is a minor, we ask that you make an agreement with your child (especially teenagers) and the provider as to what is to be released and/or participation in treatment. Privacy is often crucial for success in treatment of minors. Our clinicians will make all efforts to respect the family relationship while supporting the child's progress in treatment.

Consent is not required by the client or guardian in the following situations:

- Suspected abuse, neglect, or exploitation
- In situations where the client reports intent to harm self or others
- Legal obligation per local and state laws and as they relate to domestic violence.
- Required by law to comply with legal authorities in investigations or public health risks reporting.

Communication between health providers is important to ensure that you receive comprehensive and quality care. Signing below will allow our staff to share protected health information (PHI) with your Primary Care Physician (PCP). The information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication information. By completing this form, I am giving my Behavioral Health Provider permission to share PHI with my PCP.

Patient Name: _____

PCP Name: _____

PCP Phone: _____

PCP Address: _____

Purpose: To facilitate understanding and support of my long-term recovery.

Type of Information: Treatment planning, patient progress, discharge planning

This consent can be withdrawn by me in writing at any time. I cannot, however, take exception to actions that have taken place before I withdraw my consent.

_____ _____

Patient Signature **Date**

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Patient Rights:

1. The patient has the right to be treated with dignity and respect. The patient will not be abused or mistreated.
2. The patient shall retain all rights benefits, and privileges guaranteed by law.
3. The patient shall be considered legally competent unless a court rule otherwise.
4. The patient has the right to see their medical record with the permission of the physician. Staff will prepare and keep current the record of condition and treatment.
5. The patient has the right to know their record of progress in treatment. Staff will communicate with the patient regularly to discuss their progress and participation in treatment.
6. The patient has the right to confidentiality. Staff will not disclose information regarding the patient without a signed consent by the patient to release the information.
7. The patient has the right to consultation with other medical or service specialists when indicated.
8. The patient has the right to seek treatment elsewhere. Staff will facilitate the transfer of treatment with signed consent of the patient.
9. The staff are committed to providing an effective therapeutic environment for the benefit of all.
10. The patient has the right to file a grievance with staff without fear of retaliation.
11. The patient has the right to have their property treated with respect.
12. Patients have the right to have family or guardian to act for them if they are unable.
13. The patient has the right to practice their own religion.

Patient Responsibilities:

1. Patients will be available on time for their scheduled treatment. If the patient needs to cancel an appointment or feels they will be late for an appointment in person or via telemedicine the patient is requested to notify the clinic 24 hours ahead of time.
2. Abusive language, physical violence, and destruction of property will not be tolerated. Threats of physical violence will not be allowed. Patient shall not express profanity toward other patient's or staff.
3. Patients are responsible for taking prescribed medications independently.
4. Patient are expected to keep the names and information of other patients confidential.
5. Patients who do not observe these rules may be subject to discharge from the clinic.
6. Patients will actively participate in treatment planning and goal setting.

Signature: _____ Date: _____

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* 7185135w17246 A-Consent

GENERAL CONDITIONS OF TREATMENT

Patient Name: _____ DOB: _____

Telehealth: You may be offered a clinical encounter using videoconferencing technology. You will be able to see and hear the provider and they will be able to see and hear you, just as if you were in the same room.

Telecommunications: By signing below, I understand this practice utilizes appointment reminders, scheduling of appointments, etc. via telephone or email. I understand this use of technology is imperative to my continued treatment. I agree to all forms of electronic communications billing, appointment reminders, or any other necessary communication. I understand that protected health information will not be released without my permission, and I can revoke or change patterns of communication at any time. This clinic will only utilize phone numbers or emails provided by the patient.

Assignment of Benefits: I hereby authorize payment directly of all benefits under the insurance coverages identified to the provider/practice. I also assign payment of unpaid charges to the provider/practice whose services are utilized. Further, I assign benefits payable for other physicians/providers or organizations whose services are utilized. Unless other payment arrangements have been made with this provider. I certify information given by me by applying for payment under Social Security Act is correct for Medicare benefits and authorize payment on my behalf to the provider/practice (if applicable). I understand that I am responsible for providing up to date insurance information and any unpaid balances.

Release of Information: This clinic, providers and others providing services may at their discretion, disclose all or part of a patient's record to any corporation which is or may be liable for all or part of the total charge incurred, including but not limited to; insurance companies, worker's compensation carriers, welfare funds, Social Security Administration, or intermediaries, as well as corporations engaged by this provider to collect unpaid charges. By signing below, you are authorizing the release of statistical information as required by any local, state, or federal agency as may be required by Managed Care Programs. I understand that my rights to confidentiality are maintained otherwise, unless ordered by the courts, suspected abuse, risk of self-harm or harm to others.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withdraw my consent at any time.
3. I agree that I am responsible for charges resulting from the services rendered in person or using videoconferencing technology at heir prevailing rates.

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4. I agree and consent to the services that are provided within the scope of their practice and understand everything in this encounter is confidential except for information required by law for reporting.
5. I acknowledge that I have received/reviewed and understand my rights as a patient with this provider/practice.

Patient Informed Consent and Assignment of Benefits: I have read and understand the information provided above regarding in person or telemedicine/psychiatric care, and all my questions have been answered to my satisfaction. I hereby give my informed consent for services provided by this agency.

Signature of Patient (or authorized person) _____ Date _____

If authorized signer, relationship to patient _____