Brandywine Valley Psychiatry

2300 Pennsylvania Ave #4C Wilmington DE 19806
Phone 302 635 0517 eFax 570 221 6246

New Patient Information Form

Name: _____ Today's date: _____
Address: _____
Contact numbers: _____ E-mail: _____
DOB: _____ Age: _____
Marital status: _____
Number of children: _____
Occupation: _____
Emergency contact (name, phone and relationship): _____
Referred by: _____
Primary care doctor name and contact information:
_____

Medical History

Describe your chief complaint and reason you are coming to see a psychiatrist:

Please check any medical conditions that apply:

__High blood pressure	__Diabetes	__Heart attack/angina
__Stroke	__Asthma	__Thyroid gland disease
__Seizures or epilepsy	__Stomach ulcer	__Cancer (specify type)
__Liver disease	__Kidney disease	__Multiple sclerosis
__Glaucoma	__Parkinson's disease	__Irritable bowel syndrome
__Ulcerative colitis/Crohn's	__Head injury & loss of consciousness	

Other significant medical conditions? _____

Current Medications & Dosages:
_____
Previous Psychiatric Medications:
_____

Do you have any medication allergies?
__No __Yes Specify: _____
Have you been under the care of a psychiatrist?
__No __Yes Specify: _____
Have you ever been admitted to a psychiatric hospital?
__No __Yes Specify: _____
Have you ever attempted suicide?
__No __Yes Specify: _____
Do you have a history of aggressive behavior?
__No __Yes Specify: _____

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Controlled Substance Agreement

I agree to the following terms regarding the use of controlled substances as part of my treatment:

1. **Provider Coordination**: I will only obtain controlled substances from Brandywine Valley Psychiatry and will inform my provider if I receive medications from another source. This includes pain medications, muscle relaxants, sedatives, anxiolytics, or stimulants.
2. **Medication Safety**: I will not sell, share, or misuse my medications. I will store them safely, carrying only the necessary amount when away from home. Lost or stolen medications will not be replaced under any circumstances.
3. **Prescription Adherence**: I will take medications exactly as prescribed and will not request early refills. No refills will be provided at night or on weekends, and I understand that refill requests typically require 48-72 hours' notice.
4. **Legal & Health Obligations**: I understand that if I am arrested or incarcerated for drug-related charges, my treatment with controlled substances may be discontinued, and my care may be terminated. If I become pregnant or suspect pregnancy, I will notify my physician immediately.
5. **Pharmacy Use**: I agree to use only one pharmacy for controlled substances and will notify the office of any changes. If I need to switch pharmacies, I will resubmit this agreement with the updated information.
6. **Monitoring Compliance**: I agree to provide urine or blood samples for drug testing as requested by Brandywine Valley Psychiatry. I understand that my prescription history may be monitored through the Prescription Drug Monitoring Program (PDMP) to ensure safe and appropriate use of controlled substances.
7. **Treatment Commitment**: I will attend all scheduled appointments with my provider, including those related to mental health, pain management, and substance abuse treatment. I understand that the goal may be to reduce or discontinue controlled substances over time, and I may be required to explore alternative treatments to address the root cause of my pain.

Pharmacy Information:
(Name, Address, Phone & Fax): _____

I understand that failure to follow this agreement may result in termination of care.

Patient Name (Printed): _____
DOB: _____
Patient Signature: _____
Date: _____

Responsible Party (Printed): _____
Signature: _____
Date: _____

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HIPAAA Notice & Consent for Treatment

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 sets national standards for the protection of your personal health information (PHI). Key components include:

1. **Privacy Rule:** Governs the protection and authorized disclosure of personal health information.
2. **Electronic Transaction Rule:** Ensures the safeguarding of PHI during electronic transmissions.

As your healthcare provider, I am legally required to:

- Secure agreements with business associates to protect your PHI.
- Ensure my privacy and security practices comply with HIPAA standards.
- Provide you with a description of my privacy practices.
- Obtain your signature acknowledging receipt of this information.

Notice of Privacy Practices

This notice explains how your medical information may be used and disclosed, and how you can access it. Please review it carefully.

Confidential information disclosed during treatment will remain private unless authorized by you or required by law. By signing this document, you consent to sharing information with other healthcare providers involved in your care as deemed clinically necessary. Inform me if you wish to withhold specific information.

Uses and Disclosures of Medical Information

Your PHI may be used for:

- **Treatment:** Coordinating care with other providers. Example: Sharing test results with another doctor.
- **Payment:** Billing and reimbursement activities. Example: Submitting a claim to your insurance company.
- **Healthcare Operations:** Managing business aspects of the practice. Example: Quality assessments.

In emergencies where there's an imminent risk of harm, necessary information may be disclosed to law enforcement, treatment facilities, potential victims, or next of kin to ensure safety. PHI may also be shared with my liability insurer when necessary.

Other uses of your PHI will require your written authorization, which you can revoke at any time.

Your Rights Regarding PHI

You have the right to:

- Request restrictions on certain uses and disclosures of your PHI.
- Request confidential communications by alternative means or at alternative locations.
- Inspect and obtain a copy of your PHI.
- Request amendments to your PHI.
- Receive an accounting of PHI disclosures.
- Obtain a paper copy of this notice.

Legal Obligations

I am required by law to maintain the privacy of your PHI and provide you with this notice. Any changes to these practices will be communicated to you. You may file a complaint with my office or with the Department of Health & Human Services if you believe your privacy rights have been violated.

For more information or to file a complaint, call toll-free: 1-877-696-6775.

Acknowledgment of HIPAA & Notice of Privacy Practices

I, _____, acknowledge that I have received and reviewed the Notice of Privacy Practices from Brandywine Valley Psychiatry.

Consent to Treatment

I, _____, consent to receive treatment from Brandywine Valley Psychiatry. I understand that I may withdraw this consent at any time by submitting a written request.

Legally Responsible Party Name: _____

Legally Responsible Party Signature: _____

Date: _____

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Practice Policies & Information Guide

Introduction:
This guide provides a clear understanding of our practice policies, including those related to fees, insurance, and confidentiality. If you have any questions, please do not hesitate to ask for clarification.

Fee-for-Service Practice:
Brandywine Valley Psychiatry operates on a fee-for-service basis and does not accept any form of insurance. **Brandywine Valley TMS**, which provides Transcranial Magnetic Stimulation (TMS) therapy, is a separate practice with its own Tax ID and NPI numbers. Although the psychiatrists at **Brandywine Valley Psychiatry** may be listed as in-network with some insurance providers, this in-network status only applies to services provided by **Brandywine Valley TMS**.

Submitting a receipt for services rendered by **Brandywine Valley Psychiatry** to your insurance provider will not be reimbursed under in-network benefits, as the in-network status only applies to **Brandywine Valley TMS**. If you have any questions about which practice accepts your insurance, please ask for clarification.

Upon written request, Brandywine Valley Psychiatry will provide a receipt for services rendered, which patients may submit directly to their insurance provider if they have out-of-network benefits. Please note that Brandywine Valley Psychiatry is out-of-network with all insurance plans. While we can provide a receipt, we do not complete insurance forms, prior authorization requests, reimbursement paperwork, or any other documents submitted by patients for the purpose of seeking insurance reimbursement. Submission of a receipt to your insurance carrier does not guarantee reimbursement and is subject entirely to your insurer's policies and your specific out-of-network coverage. Any bill submitted to you by Brandywine Valley Psychiatry is due upon receipt. Unpaid balances will be subject to a 1.5% monthly finance charge from the date services were rendered. If your account is sent to a third-party collection agency, you will be responsible for all collection costs, including any reasonable attorney fees incurred in the process.

Payment Methods and Fees:
Payment is due in full at the time of your appointment. We accept credit cards, electronic payments, and checks, but a valid credit card must remain on file. If a check is returned or unpaid, a $50 fee will apply, and the credit card will be charged. Additionally, if payment is not received within one month of

services rendered, the credit card on file will be charged the full fee, in addition to the 1.5% monthly finance charge previously mentioned, regardless of the preferred payment method.

Credit card number _____

Exp. date _____ CVV _____

Billing address _____

Our practice includes two psychiatrists:

- **Amanda Castro, MD** (Adult patients):
  - **Initial Evaluation (90 minutes):** $595
  - **Follow-up Appointment (30 minutes):** $275
- **Amanda Castro, MD** (Child/Adolescent patients):
  - **Initial Evaluation (90 minutes):** $725
  - **Follow-up Appointment (30 minutes):** $295
  - These higher fees reflect the additional expertise and time required for evaluating children and adolescents, including parental interviews.
- **Jack Castro, MD** (Adult patients):
  - **Initial Evaluation (90 minutes):** $595
  - **Follow-up Appointment (30 minutes):** $275

Fees may be adjusted and prorated in 15-min increments when appointment times exceed the stated duration listed above.

Appointment Cancellations:
If you need to cancel or reschedule an appointment, please do so at least 24 hours in advance. Cancellations made within 24 hours of the appointment time or missed appointments will incur the full appointment fee. For Monday appointments, cancellations must be made by the previous Friday during business hours to avoid last-minute fees. A $50 fee applies to bounced, invalid, or returned checks.

Continuity of Care:
Regular appointments are essential for continuity of care. If you miss or cancel an appointment, please reschedule as soon as possible. If we do not hear from you within a week, we will attempt to reach you twice. If there is still no response within another week, we will assume you are no longer interested in continuing services, and your file may be closed, resulting in discharge from the practice. Additionally,

we may reach out to your emergency contact to inquire about your status. Resuming care after file closure requires completing new patient forms and undergoing a new evaluation at the standard fee.

Medication Refills and Prescription Requests:
You are responsible for requesting medication refills at least 5 days before running out. Waiting until the last day may risk treatment interruptions if we are unavailable. Prescriptions will be provided during your appointments to cover you until your next visit. Requests for prescriptions outside of appointment times may incur a $25 fee.

Communication and Emergencies:
You may leave telephone messages at (302) 635-0517, which are checked regularly during business hours (9 AM - 5 PM, Monday - Friday). In case of an emergency, call 911 or visit the nearest emergency room. For secure communication, we require using the Office Ally/Patient Ally portal. Brief telephone consultations are typically free, but frequent or lengthy consultations may incur charges.

Administrative and Prior Authorization Fees:
The fee schedule listed above may apply to time spent on non-face-to-face services, including obtaining prior authorizations for medications or tests, coordinating care with other professionals (such as physicians or therapists), and completing administrative tasks such as disability forms or additional paperwork, depending on the time required.

Signature Section:

Patient Name:

Patient Signature:

Legally Responsible Party (if applicable):

Signature:

Date:

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Permission to Release & Request Medical Records

Date: _____

To (your PCP, therapist, other healthcare provider, school, or third party):
Name: _____
Address: _____
Phone #: _____
Fax #: _____

I hereby authorize **Brandywine Valley Psychiatry** to **release** and/or **request** my medical records to/from the individual or organization listed above.

Patient Name: _____
Date of Birth: _____

Patient or Legally Responsible Party Signature: _____

If not signed by patient, print name & state relationship: _____

Release of Information to Family/Friends

I give my permission to **Brandywine Valley Psychiatry** to share personal health information about me with the individuals listed below. These individuals will only receive information related to their involvement in my care or payment for my care. They may communicate with **Brandywine Valley Psychiatry** via the patient portal, email, phone, text, or in person to schedule appointments, discuss my after-visit summary, test results, billing, and other matters related to my psychiatric care.

Name: _____**Phone Number:** _____
Relationship: _____**Email:** _____

Patient Signature (or Authorized Representative): _____
Date: _____

Printed Name & Relationship (if not patient): _____