IME Behavioral Health

IME Behavioral Health, LLC

PATIENT INFORMATION FORM

Name: _____

DOB: _____

Address: _____

_____

Email: _____

Cell phone: _____

Alternate Phone: _____

Name of Emergency Contact and Number: _____

_____

Relationship to you: _____

Name and Phone Number of Primary Care Physician: _____

_____

Insurance Company: _____

Insurance Policy Number: _____

Group Number: _____

Name of Policy holder: _____

Date of Birth of Policy holder: _____

We would love to know who referred you so we can thank them!

_____

IME BEHAVIORAL HEALTH, LLC
8840 Stanford Blvd. Suite 1600
Columbia, MD 21045

ph: 240-512-0141
fax: 240-512-0151
imebehavioralhealth.com

IME BEHAVIORAL HEALTH, LLC

INFORMED CONSENT

PROVIDER-CLIENT AGREEMENT:

Welcome to the practice! This document contains important information about our professional services and business policies. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign this or at any time in the future.

PSYCHOLOGICAL and PSYCHIATRIC SERVICES:

Therapy and psychiatric services are a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in therapy or psychiatric services, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. As your therapist/prescriber, we have corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks might include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration and helplessness, because the process of therapy often requires discussing the unpleasant aspects of your life. However, therapy has been shown to have great benefits for individuals. It can lead to a significant reduction in feelings of distress and a greater personal awareness. Therapy involves an active effort on your part. In order to be most successful, you will have to work on things outside of the session. For psychiatric services, it is important to follow all of the advice by your prescriber and to take the medication as prescribed. It is your responsibility to manage your medication and make additional appointments if you are running out of your medication.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. At the end of these sessions, we will be able to offer you initial clinical impressions and we can agree on some treatment goals. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist or prescriber. If you have any questions, please ask them at any time. If you wish to work with someone else or get a second opinion, you have a right to do so.

APPOINTMENTS:

All therapy appointments will be 50 minutes in duration, once a week at a time we agree on. However, as you start to make progress and feel better, these sessions may become less frequent. The time scheduled for you appointment is assigned to you and you alone. If you need to cancel or reschedule a session, we ask that you provide us with 48 hours notice. If you miss a session without cancelling, or cancel with less than 48 hours notice, our policy is to collect a missed appointment fee, set as $80. If you arrive to your appointment late, your appointment will still end on time.

We offer teletherapy services. These sessions can be over the phone or through our EMR. These sessions follow all of the same guidelines as face to face sessions but with the added convenience of not having to travel to the office.

The initial psychiatric appointment will be one hour so the doctor or nurse practitioner can record an accurate medical and psychiatric history. It is important to bring in a list of medications that you are already taking. After the initial visit, you will see your prescriber once every two to four weeks to make sure that you are not experiencing any negative side effects. After you are stable on a medication, your prescriber may want to see you once every three months.

PROFESSIONAL RECORDS:

We are required to keep appropriate records of the psychological services that we provide. Your records are maintained in a secure location in the office and your online medical records are on a HIPPA approved site.

CONFIDENTIALITY:

Everything that is discussed in our session is confidential. If you tell your provider that you are going to hurt yourself or someone else, then your provider is required by law to break that confidentiality. It will be discussed with you, who will be told. It may be a spouse, or close family friend or other family member. In serious cases of suicidal or homicidal plans, your provider may have to inform the police. In addition, if you have any knowledge of a child abuse situation then your provider is also required by law to inform the appropriate people. The appropriate party in this case, will most likely be child protective services.

CONTACTING US:

Your provider is often not immediately available by telephone. Your provider will not answer the phone when he or she is with a client. At these times, please leave a message on the confidential voice mail and your provider will return your phone call as soon as possible. If you are in crisis, do not wait for your therapist or nurse to return your call. Please go to your nearest emergency room or call 911.

If you need to discuss an issue that is going to take more than 10 minutes, we ask that you schedule an appointment so that you can be given the attention and time that you deserve.

You will be informed in advance of any planned absences and we will provide you with the name and phone number of the mental health professional that will be covering.

OTHER RIGHTS:

We are an LGBTQ+ and transgender friendly practice. Our practice is a safe place for all individuals. If you are unhappy with what is happening in therapy or with your psychiatric service, we hope you will talk with us so that we can respond to your concerns. Any concerns will be handled with care and respect. You may also request that we refer you to another therapist or nurse and you are free to end therapy or your psychiatric service at any time. You have the right to considerate, safe and respectful care without discrimination to race, ethnicity, color, gender, sexual orientation, age, religion or national origin. You have the right to ask questions about any aspect of therapy or psychiatric service and about our specific training and expertise. You have the right that we will not have any other relationship with you than that of provider – client.

TERMINATION OF TREATMENT:

You have the right to terminate therapy/psychiatric service at any time and for any reason. It is our hope that termination of therapy will naturally come after you feel that you have made progress on all of your therapy goals and are feeling a general sense of well-being. You are encouraged to make an appointment in the future if you ever need a "check-up" or would like to restart therapy for different issues. For psychiatric treatment, it is important that you follow the advice of your prescriber and if you terminate services with him or her, do not stop your medication without their consent. If your prescriber decides to terminate treatment with you, she or he will make sure that you have a 30 day supply of your medication and will provide you with three referral sources for medication management.

CONSENT TO THERAPY:

Your signature below indicates that you have read this Agreement and agree with its terms.

Printed Name:_____ **Date:**_____

Signature:_____ **Relationship to Client:**_____

IME BEHAVIORAL HEALTH, LLC

FINANCIAL AGREEMENT

By signing below, I am accepting the terms and services and office policy as follows:

THERAPY:
I understand that fees for services are billed at the following rates:
Initial Visit: **$225**
50 minute Therapy Session: **$175**
50 minute Family Therapy Session: **$150**

Additional Services such as Telephone Consultations, Letters, Additional Reports, and other fees will be billed at a pro-rate of time based on $225 per hour. Forensic Evaluations, Legal Reports, Testimony and Travel Time are billed at $250 per hour.
_____ initial

MEDICATION APPOINTMENTS:
I understand that fees for services are billed at the following rates:
Initial 60 minute visit: **$275**
20 minute med check: **$150**
30 minute med check: **$180**

All Missed Appointments or Appointments Not Cancelled within 48 hours will be charged directly to you at the rate of $80. Being 15 minutes late to a Telehealth Appointment also qualifies as a Missed Appointment. Missed or Cancelled Appointments are not Billable to your Insurance Company. _____initial

Any check that is returned due to insufficient funds will incur a $35 charge to your account. _____initial

Erica M. Dixon, LCPC, LCADC is contracted with Blue Cross Blue Shield, Johns Hopkins USFHP/EHP and United Healthcare

Indrani Mookerjee, DSW, LCSW-C is contracted with Blue Cross Blue Shield, Johns Hopkins USFHP/EHP, Medicare, Cigna, United Healthcare, Care First Medicare Advantage and Hopkins Medicare Advantage, Tricare Prime and Select

Matthew Stevens, LCSW-C is contracted with Blue Cross Blue Shield, Johns Hopkins USFHP/EHP, Medicare, Medicare Advantage plans for Blue Cross and Hopkins only, Tricare Prime and Select and United Healthcare

Kayla Scrandis, DNP, CRNP-PMH is contracted with Blue Cross Blue Shield, Johns Hopkins USFHP/EHP, Medicare, Cigna and United Healthcare, Care First Medicare Advantage and Johns Hopkins Medicare Advantage, Tricare Prime and Select

Mary Stoops, LCPC is contracted with Blue Cross Blue Shield, Cigna and Tricare Prime and Select.

Amena Zaman, LCSW-C is contracted with Medicare, Blue Cross Blue Shield, and United Healthcare and Cigna.

We do not have contractual relationships with any insurance company not listed above. If you do have other insurance, we will generate a superbill for you to submit to your insurance carrier in order to receive out of network benefits. This does not waive your responsibility for fees incurred. Please consult with your insurance carrier to determine what services will be covered under your particular plan. By signing below, you agree to indemnify our office from any error or omission in the preparation or filing of your insurance claim. It is your responsibility to make sure that insurance claims have been filed and are complete. If you would like us to file a claim on your behalf, please complete the patient information form completely and do not use nicknames.____initial

All precertification of services and continued certification of services for non contracted insurances are your responsibility. You agree to pay for any services denied due to lack of precertification or required notification to your insurance plan.____initial

Unless otherwise agreed to in writing, I understand that accounts are due on receipt. Interest at a rate of 1.5% per month will be charged to any accounts 90 days past due. If this account is referred to any agency or attorney for collection proceedings, I will pay all costs incurred in the collection of this account including but not limited to attorney's fees in the amount of 50% of your account balance at the time that account is placed.

_____

Signature of Guarantor/Financially Responsible Party Date

_____

Printed Name

_____

Signature of Client Receiving Services Date

IME BEHAVIORAL HEALTH, LLC

RELEASE TO FILE INSURANCE CLAIM

IME Behavioral Health, LLC is authorized to apply for benefits on my behalf for covered services rendered to me by same, under my insurance plan. I request payment from my insurance carrier be made directly to IME Behavioral Health, LLC. IME Behavioral Health, LLC is further authorized to release any necessary information, including medical information, to my insurance company in order to determine benefits to which I am entitled.

This Authorization to release information may be revoked in writing.

_____

Guarantor/Financially Liable Party Date

_____

Printed Name

_____

Signature of Client Receiving Treatment Date

OR

I do not want a claim to be filed to my insurance carrier.

_____

Guarantor/Financially Liable Party Date

_____

Signature of Client Receiving Treatment Date

IMPORTANT:

Lawsuits and other Legal Proceedings: We may use or disclose personal health information when required by a court or administrative tribunal order. We may also disclose PHI in response to subpoenas, discovery requests or other required legal process when efforts have been made to advise you of the request or to obtain an order protecting the information requested.

If services are contracted by patient's legal counsel, worker's compensation and/or opposing legal entities, all work product is the property of the contracting entity. Our office does not represent the client nor makes any promises as to finding or outcomes. Patient does not have the right to restrict the release of information.

GOVERNMENT INSURANCES – PLEASE READ AND SIGN:

Under section 1862(b)(2) of the social security act, I confirm that these services are not the result of an accident in which another liable insurance may be responsible to pay. I further attest that these charges will not become part of a lawsuit against another liable party.

_____

Guarantor/Financially Liable Party Date

_____

Printed Name

_____

Signature of Client Receiving Treatment Date

IME BEHAVIORAL HEALTH, LLC

RELEASE OF INFORMATION

I hereby authorize IME Behavioral Health, LLC to receive/release information about

CLIENT NAME:_____ DOB:_____

for the purpose of coordinating care/completing medical records requests with:

NAME OF THERAPIST/PSYCHIATRIT/AGENCY/OTHER:_____

Address:_____

Phone:_____ Fax:_____

The information to be disclosed includes:

_____Evaluations, Reports, Progress Notes

_____Discharge Summary

_____Treatment Plan, Recovery Plans, Aftercare Plans

_____Test Results/School Records

_____Payment/Billing Information

_____Appointment Record

_____Medication Summary

Other:_____

This release of information shall remain in effect until:_____

Printed Name:_____ Date:_____

Signature:_____ Relationship to Client:_____

*I understand that this authorization is voluntary and is not a condition of my treatment or payment.

*I understand that I may revoke this authorization in writing at any time.

*I understand that my information is no longer protected by HIPPA.

*I understand that I may be charged a fee for any medical records associated with this authorization.

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

IME Behavioral Health

CREDIT CARD AUTHORIZATION FORM

Please complete all sections. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled.

Credit Card Information					
Card Type:	MasterCard	Visa	Discover	AMEX	Other
Cardholder Name (as shown on the card):					
Last 4 digits of the Card Number:					
Expiration Date (mm/yyyy): Zip Code:					

I, _____, authorize IME Behavioral Health, LLC to charge my credit card above for agreed upon fees. I understand that my information will be saved in Square to file for future transactions on my account.

_____

Customer Signature

_____

Date

IME BEHAVIORAL HEALTH, LLC
8840 Stanford Blvd. Suite 1600
Columbia, MD 21045
ph: 240-512-0141
fax: 240-512-0151
imebehavioralhealth.com