Psychiatry 280, P.C., Samuel Polek, M.D., 2803 Greystone Commercial Blvd, Ste 12, Birmingham, AL 35242
Office: (205) 968-1227 Fax: (205) 968-1229 Email: kristen@psychiatry280.com

To assist us in providing you with quality services, please fill out this form ***completely*** and sign where indicated.

Name _____ Date _____
Date of birth _____ SSN _____
Address _____
City _____ State_____ Zip _____
Home phone _____ Cell phone _____
Email _____ Preferred method of contact _____
Do you have ***ANY*** medication allergies? _____
What pharmacy do you use? _____
Who referred you to this clinic? _____
Who is your Primary Care Physician? _____
What is the main reason you are seeking treatment? _____

Insurance information:
Primary Insurance: _____ Policy #: _____
Group #: _____ Policy Holder/Subscriber Name: _____
Date of Birth: _____ Relation to Patient: _____

Secondary Insurance: _____ Policy #: _____
Group #: _____ Policy Holder/Subscriber Name: _____
Date of Birth: _____ Relation to Patient: _____

If you are insured under a spouse/parent/guardian, then the following information is necessary:
Spouse/parent date of birth _____ Spouse/parent SSN _____
Spouse/parent address _____
City _____ State _____ Zip _____

Psychiatric History

Name of last psychiatrist _____
Name of last therapist _____
List any prior psychiatric diagnoses _____
List past psychiatric hospitalizations _____
_____
Prior psychiatric medications _____
_____
_____
Have you ever attempted suicide? If so, how was it attempted? _____

Please check ***all*** of the following symptoms/thoughts that apply to you currently or within the past six months:

- ☐ Depressed mood
- ☐ Diminished interests/pleasure
- ☐ Sleep disturbance
- ☐ Fatigue
- ☐ Change in appetite
- ☐ Hopelessness
- ☐ Pleasure in few activities
- ☐ Weight change
- ☐ Agitation
- ☐ Excessive worry
- ☐ I feel like I am losing control
- ☐ Irritability
- ☐ Poor Concentration
- ☐ Tension
- ☐ Panic attacks
- ☐ Socially withdrawn
- ☐ Use of alcohol to cope
- ☐ Use of recreational or other drugs to cope
- ☐ Use of tobacco
- ☐ Anxiety in social settings
- ☐ Makes careless mistakes
- ☐ Does not complete tasks
- ☐ Difficulty organizing
- ☐ Forgetful
- ☐ Confusion
- ☐ Disorientation
- ☐ Compulsive checking/counting
- ☐ Indecisiveness
- ☐ People talk about me
- ☐ Paranoia
- ☐ Some people want to hurt me
- ☐ I feel emotionally distant from others
- ☐ I hear voices/sounds others do not hear
- ☐ I see things others do not see
- ☐ I smell/taste things others do not smell/taste
- ☐ I have racing thoughts
- ☐ I do risky/dangerous things
- ☐ Little interest in sexual activity
- ☐ Sexual problems
- ☐ Gender concerns
- ☐ I don't like my body
- ☐ Binge eating
- ☐ Self-induced vomiting
- ☐ Laxative abuse
- ☐ Excessive fasting
- ☐ Intense fear of weight gain
- ☐ Impulsive
- ☐ I think about hurting myself
- ☐ I have tried to hurt myself
- ☐ Sometimes I wish I were dead
- ☐ I think about hurting someone else
- ☐ Exposed to a significant traumatic event
- ☐ Recurrent distressing dreams

Medications you currently are taking/prescribed (including dose/frequency)

_____
_____
_____
_____
_____
_____

Please list any medical problems for which you're currently receiving treatment:

_____
_____
_____
_____
_____

Social History

Employer/School _____
Marital status _____ Children _____
Legal problems _____
Do you smoke tobacco products? _____ Do you consume alcoholic beverages? _____
Do you use any recreational drugs? _____

Family History

Is there any history of mental health issues in your family? If so, please specify.

_____
_____
_____
_____

Emergency Contact: _____ Relationship: _____
Address _____
City _____ State_____ Zip _____
Home phone _____ Cell phone _____

I consent to treatment by Samuel Polek, M.D., of Psychiatry 280, P.C. I understand that payment is to be made at the time of the treatment and that I am financially responsible for all scheduled appointments unless a minimum of 24 hours' notice is given. I authorize provider of care to release my treatment records, as required, to my insurance carrier(s) for the purpose of obtaining reimbursement. I authorize payment of reasonable and customary charges to the provider of services. I also acknowledge that I have reviewed and consent to the Privacy Practices of Psychiatry 280, P.C.

Signature of Patient/Guardian: _____ Date: _____

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PATIENT FINANCIAL AGREEMENT

Please read these policies carefully and sign below, indicating that you have read and understand the policies detailed within.

INSURANCE PARTICIPATION

We are participating providers for various insurance carriers, including but not limited to: Medicare, BCBS, MHCA, United Health Care, Viva, American Behavioral Health, United Behavioral Health, Cigna, Tricare, and Aetna. Our office does not accept Medicaid.

OUR RESPONSIBILITY TO YOU:

1. To keep up-to-date records of your insurance coverage.

2. To submit medical claims to your insurance carrier on your behalf and to make appropriate appeals when claims are initially denied by your insurance carrier.

3. To help you understand the specific details of your insurance coverage and to define any out-of-pocket expenses you may incur from receiving your care from our office.

YOUR RESPONSIBILITY TO OUR OFFICE:

1. To provide accurate and up-to-date insurance information to our office. Failure to provide us with this information may lead to denial of claims and cause you to be personally responsible for charges incurred.

2. To be responsible for any out-of-pocket expenses that are owed as dictated by your insurance coverage. Depending on your insurance coverage this **may** include any of the following types of payments:
   a. "***Co-Payment***": a payment that may be required at the time of an office visit as a mechanism by which you share the cost of that visit with your insurance carrier. This is usually a flat fee paid per visit, regardless of the total amount of charges incurred.
   b. "***Co-Insurance***": a payment that shares some of the overall cost of your care with your insurance carrier. This is usually determined after the charges have been processed by the insurance carrier and an "Explanation of Benefits" or "E.O.B." has been issued. A plan will have a set ratio, for example 70/30, where the insurance carrier pays 70% of the allowed amount and you are responsible for 30%.
   c. "***Deductibles***": these are amounts that are paid out by the patient before any payments are made by the insurance carrier. A $500 deductible means that the patient is responsible for paying the first $500 of the charges incurred. Once the deductible is "met" then your insurance carrier will begin covering their portion of the allowed charges. Deductibles can be per individual or per family. Deductibles usually reset every January 1st.

3. In the event that amounts due on account of services provided to you are not satisfied when due, you shall be responsible for all costs and expenses incurred in efforts to collect any unpaid amounts due from you, including any interest charges due, court costs, and all reasonable attorney's fees. Further, in the event that a check is returned for insufficient funds, all charges incurred by us shall be your responsibility.

4. **It is the responsibility of the patient to present to their appointments on time. If you fail to show for an appointment, regardless of whether you received any form of reminder, or if you cancel your appointment less 24 hours prior to your appointment then you will be charged a $100 "no show" fee.**

I have read and agree to the polices listed above. I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his services as described. I realize that I am required to pay for non-covered services.

_____ _____

Signature Date

Psychiatry 280

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Sign and return this form prior to your initial appointment.

Schedule of fees no covered by insurance:

- **No-show fee: $100 per missed appointment**
- **Letters (pet companion, school accommodations, etc): $50**
- **Forms: $50-100 ($100 will be charged for the completion of lengthy forms such as disability paperwork)**

Patient signature _____ Date _____

Psychiatry 280, P.C.

Notice of privacy practices

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.

Effective as of January 20, 2015

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. "Protected health information" is information about you, including demographic information that may identify you and that relates to your past, present or future physical or mental health or condition and related care services. We are required to abide by the terms of our Notice of Privacy Practices ("Notice") currently in effect. We reserve the right to make changes to the terms of our Notice and to make such new Notice provisions effective as to all your protected health information ("PHI"). We will post each revised Notice in our office, make copies of the revised Notice available upon request and post the revised Notice on our web site.

Uses and disclosures of protected health information without your consent:

Treatment. *We may use or disclose your PHI to provide and coordinate your health care and related services. This may include communications with other health care professionals regarding your health care, including your referral to another health care provider. For example, we may share PHI with other health care providers involved in your treatment, such as [sending a copy of your medical records to a specialists to whom you are referred] or [sending certain PHI to a laboratory that is conducting your tests] or [with a pharmacy when calling in your prescription].*

Payment. *We may use or disclose your PHI to obtain payment or be reimbursed for the health care and related services we provide for you. Such disclosures can be made to billing services, collection departments or credit bureaus. For example, even before you receive services, we may disclose your PHI with your health plan(s) to determine coverage eligibility.*

Health Care Operations. *We may use or disclose PHI in connection with certain administrative, financial, legal and quality improvement activities that are necessary for us to run our practice and to support our functions of treatment and payment. For example, we may use or disclose your PHI for licensing requirements or conducting a medical review or audit.*

Incidental Use or Disclosure*. An "incidental use or disclosure" is a use or disclosure that cannot reasonably be prevented, is limited in nature and occurs as a result of another permissible or required use or disclosure. We have set up reasonable safeguards that protect against impermissible uses and disclosures and limits incidental uses or disclosures. We also have policies and procedures that set limits to ensure that, as applicable, only the reasonable minimum necessary amount of your PHI is used, disclosed and requested for certain purposes.*

You Can Object to Certain Uses or Disclosures. *For each of the uses or disclosures of your PHI listed below, if you are present and able, we will either (1) obtain your oral permission, (2) give you the opportunity to object, or (3) reasonably infer from the circumstances, based on our professional judgment, that you do not object. If you are unable to object, we will use our professional judgment to disclose only such PHI as is directly related to such person's involvement in your health care. For uses or disclosures:*

- *to a relative, friend or other person identified by you only your PHI that is directly relevant to that person's involvement in your health care or payment for health care;*
- *to a family member, personal representative, or other person responsible for your care only your PHI necessary to notify such individuals of your location, general condition or death*

Required Uses or Disclosures. *We are required by law to disclose your PHI to you pursuant to your patient right of access and accounting as described below. We are also required to disclose your PHI to the Secretary of the Department of Health and Human Services when required for their investigation of our compliance with privacy laws.*

Our Contact with You. *We may use or disclose your PHI to provide you with appointment reminders (such as leaving a voicemail message, email, etc.), to provide you information regarding treatment alternatives or other health-related benefits and services*

Other Uses and Disclosures. *We may use or disclose your PHI when such use or disclosure is:*

- *required by law or used for law enforcement purposes;*
- *necessary for public health activities;*
- *necessary to report abuse, neglect or domestic violence;*
- *for judicial and administration proceedings;*
- *to avert a serious threat to the health or safety of a person or the public*
- *for workers compensation.*

All other uses and disclosures of your phi requires your written authorization:
You may authorize us to use or disclose your PHI for other purposes. You may revoke this authorization in writing at any time.

Your patient rights:

Restrictions. *You have the right to ask us to restrict our uses or disclosures of part or all of your PHI for treatment, payment, health care operations or to individuals involved in your care.*

Confidential Communications. *You have the right to request that communications about your PHI be delivered by an alternative means or at alternative locations. For example, you may request that we contact you about appointments only at your workplace. We will accommodate all reasonable requests.*

Access. *You have the right to inspect and obtain a copy of your PHI contained in clinical, billing and certain other records used to make decisions about you, except in certain limited situations. Instead of copies we may provide you with a summary of your PHI. You may request to see and receive a copy of your PHI by written request.*

Accounting. *You have the right to receive a listing of disclosures of your PHI made for purposes other than treatment, payment, and health care operations.*

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E-PRESCRIBING CONSENT FORM

E-Prescribing is defined as a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the point of care. Congress has determined that the ability to electronically send prescriptions is an important element in improving the quality of patient care. E-Prescribing greatly reduces medication errors and enhances patient safety. The Medicare Modernization Act (MMA) of 2003 listed standards that have to be included in an E-Prescribe program. These include:

- Formulary and benefit transactions — Gives the prescriber information about which drugs are covered by the drug benefit plan.
- Medication history transactions - Provides the physician with information about medications the patient is already taking to minimize the number of adverse drug events.
- Fill status notification - Allows the prescriber to receive an electronic notice from the pharmacy telling them if the patient's prescription has been picked up, not picked up, or partially filled.

By signing this consent form you are agreeing that Psychiatry 280, can request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

Understanding all of the above, I hereby provide informed consent to Psychiatry 280 to enroll me in the E-Prescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name: _____

Patient DOB: _____

Signature of Patient or Guardian: _____

Date: _____

Relationship to Patient: _____