PARK VIEW PSYCHIATRIC & NEUROLOGY SERVICES
105 CRESCENT AVE.
SUITE #1
LOUISVILLE, KY 40206

Please fill out all fields marked with an asterisk on each page completely BEFORE your appointment.

As a reminder, copays are due at the time of service. This office is a new satellite office and does not have a credit card machine yet. All payments received in the office will have to be in the form of check or cash. If you have a flexible spending account or credit card you would like to use, please contact our office at the number below to make that payment.

For questions in regards to this packet please contact:

Kim Johnson (812)282-1888 Ext 0
Email: kjohnson@pvpsychiatric.com

PARK VIEW PSYCHIATRIC & NEUROLOGY SERVICES

510 Spring Street – Jeffersonville, Indiana 47130-3591
(812) 282-1888 – FAX 285-8392

Client Information:

Name: ______________________ Age: ________ DOB: ____________

SSN: ____________________

Home Address: ____

City: ______________________ State: ____________ Zip: __________

Home Phone: ____________________

If needed, may we contact you at home? YES NO

Work Phone: ____________________

If needed, may we contact you at work? YES NO

Cell Phone: ____________________

If needed, may we contact your cell? YES NO

Email Address: ____

Responsible Party Information (Please fill out if client is minor)

Name: ________________________

Mailing Address: ____________________________________

City: ______________________ State: ____________ Zip: __________

Home Phone: ________________________

If needed, may we contact you at home? YES NO

Work Phone: ________________________

If needed, may we contact you at work? YES NO

Cell Phone: ________________________

If needed, may we contact your cell? YES NO

Emergency Contact:

Name: ____________________ Relationship: ______________

Phone: ____________________

POLICY HOLDER INFORMATION:

Insurance Company: ____________________ Insurance ID #______________

Policy Holder's Name: ____________________

Policy Holder's Date of Birth: ________________________

Policy Holder's Employer: ____________________________

Policy Holder's address if different than client: ____________________________

Client relationship to insured.(please circle one): Self Spouse Child Other

How did you hear about us? (check one) ( ) Physician ( ) Yellow Pages

( ) Insurance ( ) EAP Program ( ) Friend/Relative ( ) Brochure ( ) Website

( ) Other: ______________

Is there court involvement with you or your child? YES NO

*Please return this form with a copy of your insurance card and driver's license!

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Welcome to Park View Psychiatric Services. This packet contains important information about services and business policies as well as information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights with regards to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment and health care operations. The law protects the privacy of all communications between a patient and a therapist, physician or nurse practitoner. In most situations, information can only be released to others if you sign a written authorization form that meets legal requirements imposed by HIPPA. There are other situations that require only that you provide written, advanced consent.

I, ______________________ authorize PARKVIEW
(client's name) (Agency Name)

to release and/or obtain the following information related to my treatment:
(check all that apply. **Only those listed will be allowed to call or obtain information.** If using insurance, this must be checked for billing purposes.)

________ Insurance Company Name: ________________ Phone: __________
________ Employer Name: ________________ Phone: __________
________ Spouse Name: ________________ Phone: __________
________ Parent or Guardians: ________________ Phone: __________
________ Other Relationship: ________________ Phone: __________

Time limitation for this release ________________ or ________ No Limitation
I understand I may revoke this authorization at any time. This request is to be made in writing.

I further understand that this information will be confidential and cannot be released to any party not named above, including spouses or parents. Federal law prohibits myself or any of the above named individuals/agency from re-disclosing this information without my consent. Due to HIPPA regulations, we usually require the patient to personally pick up copies of documents or confidential information. We do not usually fax confidential information due to HIPPA. We also no not mail confidential information to other parties, such as attorneys, without a court order.

Billing information and statements are not considered confidential medical information and will be sent to the patient's home address.

For reminder appointments, I give my permission to ____call me or _____email me regarding appointments or treatment issues. If I have caller ID, I am aware that Park View Psychiatric will show up on my phone. I give permission for these calls to occur _________. I decline ______ to receive reminders of my appointments. If permission is not given, I understand that it is possible I will not be informed of scheduling changes where the provider is not able to be in the office.

______________________________ ______________
Signature of Patient, Parent, Personal Representative Date

Authorization to Disclose Protected Health Information to Primary Care Physician

Communication between behavioral health providers and your primary care physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share protected health information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

N/A

(Member Name) (Member Identification Number-optional) (Subscriber Identification Number) (Date of Birth-MM/DD/YYYY)

authorize Park View Psychiatric Services to release protected health information related to my evaluation and treatment to:
(Provider Name – Please Print)

Primary Care Physician Name: ______ Primary Care Physician #: ______

Primary Care Address: ______ (Street) ______ (City) ______ (State) ______ (Zip Code)

Information to be completed by Behavioral Health Provider

I saw ______ on ______ for ______
(Patient Name – Please Print) (Date) (Reason / Diagnosis)

Summary: ______

The following medication was or will be started (indicate medication & dosage): ______

If no medication is indicated, check as appropriate:

___ Medication not prescribed ___ Patient refused medication ___ Psychotherapy suggested before trying medication

Treatment recommendations:

Lab tests for the following: ___ CBC ___ Thyroid Studies ___ Chem Panel ___ EKG

Other treatment recommendations: ______

If you have any questions or would like to discuss this case in greater detail, please call me at: ______ (Phone Number)

(Provider Signature) (Provider Printed Name) (Licensure)

Patient Rights

- You can end this authorization (permission to use or disclose information) any time by contacting: ______
- If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You cannot be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- You have a right to a copy of this signed authorization. Please keep a copy for your records.
- You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on the date specified below, within one (1) year or ~~less~~ from the date of signature. I have read and understand the above information and give my authorization: PATIENT PLEASE CHECK ONE

___ To release any applicable mental health / substance abuse information to my primary care physician.
___ To release only medication information to my primary care physician.
___ I DO NOT give my authorization to release any information to my primary care physician.

(Patient Signature) (Date) Expiration Date (Signature of Patient's Authorized Representative) (Date)

If signed by Authorized Representative, describe relationship to patient: ______

PROVIDER: PLEASE SEND A COPY OF THIS SIGNED FORM TO THE PRIMARY CARE PHYSICIAN AND KEEP THE ORIGINAL IN THE TREAMENT RECORD

NOTICE TO RECIPIENT OF INFORMATION

This information has been disclosed to you from records the confidentiality of which may be protected by federal and/or state law. If the records are protected under the federal regulations on the confidentiality of alcohol and drug abuse patient records (42 CFR Part 2), you are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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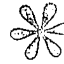
OFFICE POLICY – STATEMENT OF UNDERSTANDING

I, ______________________ have received a copy and understand the policies
Client Name

and procedures of Park View Psychiatric. I understand that Park View Psychiatric is in compliance with the Health Insurance Portability and Accountability Act (HIPPA) guidelines. I also understand my Patient Bill of Rights. The therapist may use or disclose my protected health information, for treatment, payment, and health care operations purpose.

I further understand Park View Psychiatrics' fee structure and payment policy with outlines my financial responsibly. I give consent for Park View to bill my insurance carrier or payor source on my behalf. I understand that I am responsible for the payment of services, and agree to pay any uncovered charges.



________________________________ ________________

Patient, Parent/or Personal Representative Date

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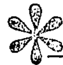
Patient Bill of Rights

Statement of Patient's Rights

Patients have the right to be treated with dignity and respect.
Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
Patients have the right to have their treatment and other patient information kept private.
Patient records cannot be released without patient permission except as required by law or in accordance with HIPPA regulations.
Patients have the right to information from staff/providers in a language they can understand.
Patients have the right to have an "easy to understand" explanation of their condition and treatment.
Patients have the right to know about their treatment choices, regardless of the cost or whether or not they are covered by insurance.
Patients have the right to get information about Parkview Psychiatric Services role in the treatment process.
Patients have the right to professional information about providers.
Patients have the right to know the clinical guidelines used in providing and/or managing their care.
Patients have the right to file a complaint or grievance with the administration of Park View Psychiatric.
Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
Patients have the right to know of their rights and responsibilities in the treatment process.

Statement of Patient's Responsibilities

Patients have the responsibility to give providers information they need. This is so the provider can deliver the best possible care.
Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
Patients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
Patients have the responsibility to treat those giving them care with dignity and respect. This includes any support staff, such as people who make appointments.
Patients should not take actions that could harm the lives of Park View Psychiatric Service employees, providers, or other patients.
Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits. Park View can terminate a client after 2 No Show or Late Cancel appointments.
Patients have the responsibility to ask their questions about their care. This is so they can understand their care and their role in that care.
Patients have the responsibility to meet their financial obligations for their services. Should a problem arise with meeting this obligation, patients must communicate with their provider to resolve the problem.
Patients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.
I have read and understand my Patient Rights and Responsibilities.

______________________________  ______________

Patient, Parent or Personal Representative — Date

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Informed Consent for Treatment

I _______________________________(name of patient), agree and consent to participate in mental health services offered and provided by Park View Psychiatric and Neurology Services, P.S.C., a mental health provider. I understand that I am consenting and agreeing only to those services that the above-named provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; or (2) the scope of licenses, certification, and training of these mental health providers directly supervising the services received by the patient. If the patient is under the age of eighteen, I attest that I have legal custody of this child and am therefore allowed to initiate and consent for treatment.

Signature: ___________________________________ Date: ____________________

Relationship to Patient: ____

Patient Name ______________________________ dob: ______________

Medication Consent Form

I have received education regarding the medication that has been prescribed to (please check one of the following) ________ me, ________ my child, or ________ a person for which I am the legal guardian, by ______________________________ (Provider prescribing medication), and consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication, and the possible effects of this medication should I, or the person taking it become pregnant. I have also been informed of the reason or intended purpose for which this medication was prescribed.

Patient/Legal Guardian Signature: ______________________________

Provider's Signature: ______________________________

Date: ______________________________

- It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their doctor **before** taking **any** medication.
- It is recommended that patients be educated on reporting all side effects they experience, including which side effects to report immediately to a health care provider.
- It is recommended that any provider prescribing medications obtain a thorough patient history that should include (but may not be limited to):
  1. what medications, including prescribed and over-the-counter medications, is the patient or has the patient been taking,
  2. what food and drug allergies does the patient have,
  3. what medical conditions does the patient have.

PARK VIEW PSYCHIATRIC SERVICES

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MEDICATION PICK-UP CONSENT FORM

*_________________________ D/O/B __________, do hereby give the following individuals authority to pick up my prescriptions and or medication samples. I, furthermore am aware that the below stated individuals must present a valid picture identification at the time of pick up.

1.

2.

3.

_________________________ _________________________

signature date

Park View Psychiatric Services
510 Spring Street
Jeffersonville, IN 47130
Phone: (812) 282-1888 Fax: (812) 285-8393

Consent For Medical Treatment And Release Of Information

1. **Consent for Health Care Services:** I authorize consent for medical treatment at Park View Psychiatric Services.
2. **Authorization for Release of Information:** Park View Psychiatric Services may release information from my medical records to any health care provider involved in my care and treatment. Park View Psychiatric Services may also release information from my medical records to any person or organization liable for all or part of my charges, such as my insurance carrier, any third-party payer, the Medicare programs, and my employer's workers' compensation carrier. I acknowledge that upon the disclosure of medical record information to an insurance company or other payer pursuant to this authorization, Park View Psychiatric Services is no longer responsible for the confidentiality of any information known or possessed by the payer.
3. **Financial Agreement:** I understand that there is no guarantee of payment from any insurance company or other payer. I agree to pay all charges for the services provided by Park View Psychiatric Services which are not paid by my health insurance or other payer. All charges are due and payable when I receive the bill. If payment is not made within 90 days from the date the bill was mailed from Park View Psychiatric Services, I understand that a delinquent charge of interest rate of 18% may be added to my bill. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file with Park View Psychiatric Services. I understand that I am responsible for a $25.00 returned check fee in addition to any other associated bank charges.
4. **Pre-authorization Requirements:** I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Park View Psychiatric Services charges.
5. **Assignment for Direct Payment:** I authorize that payment of any insurance (including auto insurance and health-care insurance) benefits for health care services or goods may be made directly to Park View Psychiatric Services.
6. **Charge for No Show/Cancellation without 24 hour notice:** I understand that 24 hour notice is required for canceling an appointment, and I will be charged a $25.00 fee for any missed appointment without required notification. I also understand that I will be responsible for this charge and that my insurance company will not be billed for that day.

I acknowledge that:

- **I have read this form and understand its contents.**
- **I am the patient, or person duly authorized either by the patient or otherwise, to sign this agreement, consent to, and accept its terms.**
- **I am responsible for the payment and/or co-payment that is due at the time of service.**
- **I have received a copy of Park View Psychiatric Services HIPAA Policy.**

____
Signature of Patient or Legally Responsible Person

____
Name (Please print)

____
Relationship/Reason Why Patient Is Unable to Sign

____
Date