MyNDSpace – Patient Registration

Patient Information

Name:					
Address:					
City:		State:		Zip:	
DOB:		Age:	Sex:		SS#:
Phone #	Home:		Work:		Cell:
Employer:			Occupation:		
Emergency Contact:			Emergency Contact #:		
Who has custody of Minor/Relationship to Minor?					

Insurance Information

Primary Insurance Carrier:			
Policy Holder Name:			DOB:
Relationship to Patient:			SS#:
Address (if different):			
City:	State:		Zip
Policy ID:		Group #:	
Policy Holder Phone:		Insurance company Phone:	

Secondary Insurance Carrier:			
Policy Holder Name:			DOB:
Relationship to Patient:			SS#:
Address (if different):			
City:	State:		Zip
Policy ID:		Group #:	
Policy Holder Phone:		Insurance company Phone:	

Financial Responsibility

Name of Responsible Party (if different):			
Relationship to Patient:			
Address (if different):			
Phone #	Home:	Work:	Cell:

Primary Care Provider (PCP)

PCP Name:	
PCP Telephone Number:	PCP Fax Number:
Authorization to Release Medical Information to PCP (includes office visit notes):	Yes No

I hereby authorize that the above information is correct and accept financial responsibility for the balances due on the account for the above patient.

Signature of Patient/Guardian:____Date:_______________

MyNDSpace– Clinic Policies/HIPAA

Patient Name:____Date of Birth:_____/____/____

What to Bring to Your Appointment(s):

- Photo Identification/Driver's License (provide update copies if any changes occur)
- Insurance Identification Card
- Completed Intake Paperwork Packet

Prescription Policy: Our clinic will only refill prescriptions at the time of a scheduled appointment. Please be proactive in monitoring the need for refills. We do not respond to fax requests for prescriptions refills.

Availability of Providers: We do not provide 24/7 call-coverage at our office. Please note that in case of emergency, we advise you to call 9-1-1 or go to your local emergency room.

Billing Service: Please note that MyNDSpace utilizes an outside agency for the purposes of billing and submitting claims to insurance providers. These individuals are provided limited access to patient demographics as required for the billing process and also maintain appropriate HIPAA compliance. We will work to assist in explaining balances in office.

HIPAA

MyNDSpace is required by the Health Insurance Portability & Accountability Act (HIPAA) to provide confidentiality for all medical/mental health records and other individually identifiable health information in our possession. This Notice is to inform you of the uses and disclosures of confidential information that may be made by MyNDSpace, and of your individual rights and our legal duties with respect to confidential information.

Release of Information: Please complete the attached release of information form to indicate any parties to which you wish to have your protected health information (PHI) released. Other than the indicated parties, our clinic may release the information for payer-source purposes (insurance companies).

Disclosures that do not require authorization to release your PHI:

- Disclosure required by law, such as a court order by a judge.
- Disclosure for use in judicial or administrative proceedings, such as a malpractice case or board complaint.
- Disclosure to maintain safety of patients or others, such as communication with probate court for commitment.
- Disclosure during emergent care situations, such as discussing care with emergency room providers.
- Disclosure for suspected abuse, neglect or domestic violence, as required as a mandated reporter and for duty to warn.

I hereby attest to having read the above information in its entirety and understand my rights as a patient as well as the policies of MyNDSpace Mental Health Education & Consulting, LLC.

Signature of Patient/Guardian:____Date:_____________

MyNDSpace Release of Information

Patient Name:____**Date of Birth:**_____/____/____

Please document below parties that you would allow medical information to be released to. It is often helpful in coordination of care if other providers are indicated on this list. Thank you!

Name of Person	Relationship to patient	Telephone Number	Medical Information	Appointments

Pharmacy Name/Location:____Phone: _____________

**Release of information pertaining only to appropriate prescription information*

Permission to Call Home or Cell?	Yes	No	Preferred #:
Permission to Leave Voicemail?	Yes	No	
Permission to Email	Yes	No	Email:
Permission for Reminder call/text	Yes	No	Preferred method:

HIPAA and Email: Please note that many popular email services (Gmail, yahoo, Hotmail) do not utilize encrypted email. When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet.

For Minors:

Due to concerns with custody, please state who has medical decision-making capacity.

____

If this is not the current representative, do you give permission for any other parent/guardian to make medical decisions? () Yes () No

Name of person(s):____

I hereby authorize the release of the medical information as documented above. I understand I retain the right to decline release of information to the above parties at any time and will notify staff of any changes that I wish to make in writing. I understand that in emergency situations the provider may contact other providers/caregivers to coordinate safe and appropriate care without my consent.

Signature of Patient/Guardian: **Date:**

MyNDSpace– Financial Responsibilities

Patient Name:____Date of Birth:______/____/____

Below is a summary of the financial responsibilities for you as a patient here at MyNDSpace.

Patients are responsible for any remaining balances that will be represented from our billing services. We do our best to help estimate patient costs including co-pays, co-insurance, deductibles and out of pocket limits. The information provided is often not up to date when patients present to the clinic, and we do our best to work with the information provided to us. Please contact your insurance company for clarification of benefits prior to your office visits to better understand your benefits as an individual.

<u>Insurance Filing:</u> Please note that we will file your claims with the insurance providers as a courtesy. We require that you provide a current ID and copy of the insurance card. These may change over time, and we require that you inform us of any changes and provide copies of new insurance cards/information. It is important that we have the most up to date information as any errors in your information can result in denied claims. This includes insurance policy ID numbers, address changes, DOB, social security number, and telephone numbers. **Please note that you will be responsible for the balance due with denied claims.**

<u>Insurance Verification:</u> Please be sure to verify coverage prior to your first visit. You as a patient are responsible for understanding your benefits for coverage. Our staff will work to provide verification of insurance benefits prior to the first visit. This helps to assure that the provider you are seeing is covered with your benefits. You are responsible for knowing your current insurance requirements for verification and coverage. Some carriers require verification, referrals from another provider (PCP), or updates when you change providers. Please feel free to contact our staff as we can help assist with any questions.

Payment is due at the time of the office visit. There may also be remaining fees as a result of insurance coverage, denied claims or other fees listed below.

Early Refills: Requests for early refills are subject to provider discretion and require an appointment.

Drug Screening: It is our policy to conduct periodic drug screens. Drug screens may be collected via oral swab or urine specimen. In the event that drug screens are not covered by your insurance provider, you will be subject to an additional fee of $25.00 at the time of screening.

<u>Cancellation/No-show Policy:</u> It is our policy that you are responsible for being aware of your upcoming appointments. We understand that certain circumstances arise that can result in the need to reschedule an appointment. We require 24-hour notice for cancellations, otherwise you may be charged a $50 fee for not showing up to your scheduled appointments. Please call the office at any time at (843)266-7573 or email at admin@myndspace.org. If you are unable to reach us, please feel free to leave a message. We will return the call when time allows. If you do not hear back, please call again to confirm that the appointment has been rescheduled.

<u>Office/Administrative Fees:</u> Please note that office staff is often required to provide documentation to patients, providers and outside agencies. The following are rates for the services rendered to complete that service.

Letters/Forms/Completed Paperwork for outside agencies: $25.00
Copies of Medical Records: $30 per page

I hereby acknowledge that I have read all of the above information regarding my responsibility as a patient at MyNDSpace, and I agree to these terms.

Patient/Guardian Signature:____Date:_______________

MyNDSpace Intake Form

Name____Date______________

What are the problem(s) for which you are seeking help?

1.____
2.____
3.____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

Depressed mood
() Unable to enjoy activities
() Sleep pattern disturbance
() Loss of interest
Concentration/ forgetfulness
Change in appetite
Excessive guilt
() Fatigue
() Decreased libido

() Racing thoughts
() Impulsivity
() Increase risky behavior
() Increased libido
() Decreased need for sleep
() Excessive energy
() Increased irritability
() Crying spells

() Poor focus
() Distractibility
() Interrupting others
() Getting off task
() Mood Swings
() Checking Behaviors
() Difficulty in crowds
() Nightmares

() Excessive worry
Anxiety attacks
Avoidance
Hallucinations
Suspiciousness
Other:

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? () Yes () No
No. If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? () Yes () No
How often do you have these thoughts? ____
When was the last time you had thoughts of dying? ____________________
Has anything happened recently to make you feel this way? ______________________________
Would anything make it better? ____
Have you ever thought about how you would kill yourself? ______________________________
Is the method you would use readily available? __________________________________
Is there anything that would stop you from killing yourself? __________________________
Have you ever tried to kill or harm yourself before?
____

Do you have access to guns? If yes, please explain. ______________________________

Current Psychiatric Medications: Please list Name, Dose and Times of Day

____
____
____
____

Past Psychiatric Medications: Please list Name, Dose and What you remember about the effect.

____
____
____
____

Family Psychiatric History: Has any one in your family ever been hospitalized, diagnosed or treated for a mental health condition? Please List the family member & the condition below.

____
____
____
____

Past Medical History:

Allergies____________________________ Current Weight____________Height ____________

List ALL current non-psychiatric prescription medications and how often you take them.

Medication Name Total Daily Dosage Estimated Start Date

____
____
____
____
____
____
____
____

Current over-the-counter medications or supplements: ___________________________

____

Consent for Behavioral Health Treatment

Consent to Services: I voluntarily consent that I will participate in a behavioral health treatment (e.g. psychological or psychiatric) by staff from MyNDSpace Mental Health Education & Consulting, LLC. Treatment may be provided by a licensed counselor, a psychologist, a psychiatric nurse practitioner, a psychiatrist, or an individual supervised by any of the professionals listed. Services may include interviews, assessment or testing, psychotherapy, and/or medication management.

Risks & Benefits: Behavioral health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. Some individuals may not improve because of treatment or may terminate before it is clinically indicated. In addition individuals may experience side effects from psychotropic. It is important to keep your clinician advised of any difficulty you may encounter during your treatment.

Treatment Compliance: After 3 repeated absences/failure to participate in services may result in discontinuation of services. If you are not scheduling sessions and/or arriving for sessions for a continuous period, we will assume you are voluntarily terminating services with us. After 6 months, you will be required to participate in another intake and assessment process.

Cause for Termination: If it is deemed that the services we provide are not beneficial for you, a decision could be made to discontinue services. Disorderly Conduct, Threatening Behavior, and/or failure to treat other clients and staff with respect can result in discharge from our services. Failure to maintain the confidentiality of others accessing services can result in discontinuation of services. MyNDSpace reserves the right to discharge clients for reasons not mentioned in this informed consent, should the need arise. Such dismissal from services would not happen without justifiable cause.

Emergency Contact: Please provide contact information for individuals we may contact on your behalf.

Name: ____ Phone Number: ____________________
Relationship to Patient: ____
Name: ____ Phone Number: ____________________
Relationship to Patient: ____

I have read and understand all conditions set forth in this Informed Consent. I consent to participate in MyNDSpace Mental Health Services.

I have read and agree with the conditions set forth in the Informed Consent. I agree to allow my minor child (name of minor) to participate in MyNDSpace Mental Health Services.

Client/Parent Signature____Date______________
Witness Signature ____Date______________

Expiration of Consent: This consent will expire at the time of discharge from behavioral health services from MyNDSpace Mental Health Education & Consulting, LLC.

MyNDSpace-Telehealth Consent

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.

Patient's Initials _______

_____ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

_____ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

_____ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of South Carolina at the time of this service.

_____ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

_____ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

_____ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

_____ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.

_____ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.

_____ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.

_____ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.

____ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.

____ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).

____ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.

____ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.

____ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.

____ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.

I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

______________________________ ______________________________

Patient or Legal Representative Signature/Date/Time | Relationship to Patient

______________________________ ______________________________

Print Patient or Legal Representative Name | Witness Signature/Date/Time

No Surprises Disclosure

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against "surprise billing".

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment.

There is also a list of fees that you may incur throughout your care at MyNDSpace that are in addition to direct counseling services and fees. These fees may occur due to the following (not an exhaustive list):

Late cancellation(anytime AFTER 24 HOURS)/Fail to Show fee: $50.00

Medical records request: $30.00

Completion of documents (FMLA, Disability, VA or other medical summary letters, etc): $25.00

Urine Drug Screen- $25.00

Please note our fees are reviewed biannually, you will be notified in advance of any changes. Consultation hourly fees includes billing for preparation time for meetings/appearances.

If you have any questions, you can contact our main office at the number listed above in this document. If you believe your rights as a health consumer have been violated, and you cannot come to an agreement with MyNDSpace, you can contact the Department of Health and Human Services at 1-877-696-6775 or www.cms.gov/nosurprises.

By signing, you are agreeing that you understand your Federal health consumer rights, and you understand the fee agreements in this document.

INSURANCE PAYMENT OPTIONS AND FEES

It is the client's responsibility to ensure that all services are paid in a timely manner. The current regular fee for assessment services is $200 for a psychiatric evaluation; medication management follow-ups range between $75-95 and individual therapy services are $65 for 30 minutes sessions and $100 for 45 minutes-1 hour. For clients who have insurance, there are specific contract rates, deductibles, copays and/or coinsurance amounts, and if you don't know the specifics of your policy, please contact your insurance carrier. There are additional non-clinical fees for reports and other documentation completion that are not covered by insurance, and they are the sole financial responsibility of the client. All co-pays, co-insurance, and deductibles are due at the time of service.

Cancellations and re-scheduled visits will be subject to a $50 charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for a session, you may lose some of that session time. The standard meeting timeframe is 30-45 minutes.

Late cancellation fees are NOT billed to insurance or EAP companies, they are the sole financial responsibility of the client. If you cannot attend an appointment, please remember to cancel or reschedule 24 hours in advance. You will be responsible for the $50 cancellation fee if you cancel your scheduled appointment less than 24 hours of the session. SELF-PAY AND OUT OF NETWORK DISCLOSURE.

In compliance with the No Surprises Act that went into effect January 1, 2022, there is now a Federal requirement for Health Care Providers to inform all healthcare consumers of their Federal rights and protections against "surprise billing".

This Act requires that we notify you of your federally protected rights to receive a notification when services are rendered by a NON-PARTICIPATING/OUT OF NETWORK healthcare provider. This allows the option for consumers to make the choice to receive care from an in-network provider if one is available.

Additionally, there is a requirement to provide all healthcare consumers with a Good Faith Estimate (GFE) of the cost of services for the duration of treatment. It is difficult to determine the actual length of treatment for mental health care; therefore, the estimate is based on the average length of treatment. More detailed information is included in the Good Faith Disclosure Document

Please note that your information can be securely stored by Athena, a HIPAA compliant Electronic Health Record System.

By signing this document, I agree to the above disclosures as it pertains to my financial account with MyNDSpace.

Patient or Legal Representative Signature/Date/Time

Relationship to Patient

Print Patient or Legal Representative Name

Witness Signature/Date/Time