PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY PLLC | 600 Julian Lane suite 640, ARDEN, NC 28704-7812
Phone: (828) 552-3504 | Fax: (828) 552-3505

Patient Name:

HIPPA ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. The Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing this acknowledgement. The terms of our Notice may change. If we change our notice, you may request a revised copy by contacting our office, viewing it electronically online on our website at www.prospectasheville.com, or you will receive a new notice the next time you are treated at our office.

The practice provides this form to comply with the Health Information Portability and Accountability Act of 1996 (HIPAA).

The patient or the legal authorized guardian or representative understands that:

- The practice has a Notice of Privacy Practices and that the patient (or legal authorized representative) has the opportunity to review this notice.
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice reserves the right to change the notice of privacy practices.

Please list the names of individuals that we may talk to about your treatment. Please note that this does not allow these individuals to obtain copies of your medical record without a complete and valid authorization from the patient or legal guardian or representative.

________________________________ ________________________________

I acknowledge receipt of the Notice of Privacy Practices.

____
Printed Name of Patient or Legal Guardian

____ ____________
Signature Date

____
Relationship to patient (if other than patient)

☐ Check if patient refused to take a copy or refused to review the Notice of Privacy Practices.

State reason for refusal, if known:

Witness: ____________________________________
Printed Name- Practice Representative

Witness: ____________________________________ ____________
Signature Date

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Patient Name: **Patient DOB:**

FINANCIAL POLICY AND CONSENT FOR TREATMENT

Thank you for choosing Prospect Behavioral Pediatrics and Psychiatry as your mental healthcare provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatment needed to restore and maintain your mental health. Therefore, if you have any questions or concerns about our payment policies, please do not hesitate to ask our staff.

1. Your insurance will be filed as a courtesy to you; however you are responsible for the entire bill **All co-payments, unmet deductibles and other patient responsible services must be paid for at the time of the visit.** If your insurance carrier applies the billed charges to your deductible, denies the service, or considers the services non-covered, you are responsible for payment of the service. **If you do not have insurance, payment in full will be expected at the time of the visit.**
2. In the event your insurance company does not pay the claim within a reasonable amount of time (45-60 days) then you may become responsible for the bill. If payment is not received within a reasonable amount of time from the guarantor, or if we receive returned mail as undeliverable, we reserve the right to place your account with an outside collection agency.
3. If your insurance plan requires referral or prior authorization, you must present this along with your insurance ID at each visit. If you do not have the referral when you arrive for your appointment, payment for the visit becomes your responsibility.
4. Return to checks will be subject to a return check fee.
5. A fee may be charged for missed appointments without cancellation in advance.
6. **PATIENT'S CERTIFICATION, AUTHORIZATION TO RELEASE INFORMATION, AND PAYMENT REQUESTS:** I certify the information given by me in applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carrier any information needed for this or a related Medicare claim. I request that payment of assigned benefits be made on my behalf.
7. **FINANCIAL AGREEMENT:** The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay the medical practice in accordance with its regular rates and terms, and if the account is referred to an attorney or agency for collections, to pay reasonable attorney's fees and collection expenses. The undersigned hereby assigns to the medical practice all insurance benefits for services provided. The undersigned agrees to be responsible for charges not covered by insurance. It is understood the obligation to pay the practice may not be deferred for any reason, including pending legal actions against other parties to recover medical costs.
8. **CONSENT FOR TREATMENT:** I hereby consent to the performance of such diagnostic procedures and/or medical treatment as deemed necessary or advisable by my physicians(s) or provider(s) at Prospect Behavioral Pediatrics and Psychiatry, PLLC. I hereby consent to the performance of all nursing and technical procedures and tests as directed by my physician(s) or provider(s). I understand that my medical care may require the collection of samples, including fluids or tissues, from my body. This may include having blood drawn or tissues removed during tests, treatment, or surgery. Further, I understand that should any staff be exposed to my blood or body fluids, my blood will be tested for bloodborne infections including hepatitis C and HIV/AIDS. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examination at Prospect Behavioral Pediatrics and Psychiatry. I have the right to refuse tests or treatment (as far as the law allows) and to be told what might happen if I refuse same. I have the right not to have any photos or videos taken of me unless I agreed to this, except as needed to treat me, unless consent has been obtained for same.
9. **ADVANCE DIRECTIVE:** ☐ I have executed an Advanced Directive ☐ I have not executed an Advance Directive

I have read and fully understand the Financial Policy and Consent to Treat, and have been given the opportunity to ask questions.

____________________________ ____________________________ ____________

Printed Name of Patient or Legal Guardian | Signature | Date

____

Relationship to patient (if other than patient)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION FOR SURESCRIPTS

Patient Name Date of Birth Social Security Number

Patient Address

I, or my authorized representative, request that health information regarding my care and treatment be released as set forth on this form:

In accordance with **NC** State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY, PLLC uses SureScripts, Inc., a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy. The information sent between these systems may include details of any and all prescription drugs I am currently taking and/or have taken in the past. This information will be utilized to PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY, PLLC.
2. This authorization may include disclosure of prescription information related to alcohol and drug abuse, mental health treatment, and/or confidential HIV related information by SureScripts, Inc. to PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY, PLLC
3. I have the right to revoke this authorization at any time by writing to PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY, PLLC. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. Signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.
5. Information disclosed under this authorization might be re-disclosed by the recipient, and this re-disclosure may no longer be protected by state or federal law.
6. This authorization expires one year from the date of my signature below.
7. THIS AUTHORIZATION DOES NOT AUTHORIZE PROSPECT BEHAVIORAL PEDIATRICS AND PSYCHIATRY, PLLC TO DISCUSS MY HEALTH INFORMATION OR MEDICAL CARE WITH ANYONE OTHER THAN THOSE PERMITTED UNDER APPLICABLE LAW.

Signature of patient or representative authorized by law Date

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Relationship to Patient Interpreter, if utilized

Witness Signature

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AUTHORIZATION FOR RELEASE OF OR REQUEST FOR HEALTH INFORMATION

Patient Name:	Date of Birth	Social Security Number:
Patient Address:		

Release Information From:	Release Information to:
Prospect Behavioral Pediatrics and Psychiatry **600 Julian Lane suite 640, ARDEN, NC 28704-7812** 828-552-3504 828-552-3505 Phone Number Fax number	______________________________ (Name of Facility, Person, Provider, Company) ______________________________ Street Address or PO Box, City, State, Zip Code ______________________________ Phone number Fax number

PURPOSE OF RELEASE: Continuity of patient care

Office/Clinic (check all that may apply):	Behavioral Health/Substance abuse and/or treatment (check all that may apply):
☐ Office/Clinic Summary ☐ Office visits/notes ☐ Physical Exam ☐ Lab reports ☐ Radiology reports ☑ Discussion/continuity of care with PMD or other designated individual, including letters ☑ Entire record (not including psychotherapy notes)	☐ Hospital/Discharge Summary(s) ☐ Physician Orders ☐ Progress Notes ☐ Medications ☐ Lab reports ☑ Discussion/continuity of care with PMD or other designated individual, including consultant letters ☑ Entire record (not including psychotherapy notes)

FORMAT:	DELIVERY METHOD:
☐ CD (charges may apply) ☐ Paper copy (charges may apply) ☐ Other:	☐ Reg US mail ☐ Pick up ☑ Fax, where permitted ☑ Telephone discussion

PATIENT'S RIGHTS - I understand that:

- I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation notice to the releasing facility or practice named above. Any cancellation will only apply to information not yet released by facility or practice.
- This is a full release of information related to: *(Please initial each section to be released below)*
  ________ behavioral health
  ________ drug and alcohol treatment or abuse issues (in compliance with 42 CFR Part 2)
  ________ genetic information
  ________ HIV/AIDS, and other sexually transmitted diseases.
- Once my protected health information is released, the recipient may disclose or share information with others and my information may no longer be protected by Federal and/or state privacy protections.
- Refusing to sign this form will not prevent my ability to get treatment, payment, enroll in health plan or eligibility for benefits.
- A fee may be charged for providing the protected health information
- I have the right to receive a copy of this form upon request

This permission expires one year after the date of my signature unless another date is written here: ________________________

Signature: ____ Print Name: _________________________ Date: ____________
Patient or legal guardian/legal representative
Relationship (which may require written proof to confirm authority to sign this form):
☐ Self ☐ Parent ☐ Legal Guardian ☐ Healthcare Agent/POA ☐ Affidavit Next of Kin ☐ Spouse ☐ Adult Child ☐ Attorney in Fact/Executor/Administrator ☐ Other: __________

Note: If a minor consented of their outpatient treatment for pregnancy, sexually transmitted diseases, or emotional disturbance without parental consent, the minor must sign this authorization. When the patient is a minor being treated for substance abuse, the minor must sign this form, regardless of who consented for treatment.
Signature of Minor: ______________________________ Print Name: _______________________ Date: ___________