Franklin
family psychiatric

New Patient Intake Information

Clinician: Wesley Lauterbach, APN

Demographic Information

Name _____ Date of Visit _____

Address _____

City _____ State _____ Zip _____

Primary Phone # _____ May we leave a message: _____

Alternate Phone # _____ May we leave a message: _____

Date of Birth _____ Age _____ Social Security # _____ Gender _____

Email _____

Occupation _____

Employer _____ Employer Phone _____

Emergency Contact _____ Phone Number _____

Relationship to the patient: Self Spouse Child Other

Insurance Information

Insurance Company _____ Phone # _____

Member ID# _____ Insured Name _____

Insured DOB _____ Insured SS# _____

Relationship to the patient: Self Spouse Child Other

Primary Care Physician _____ Phone # _____

Current Medications (Include prescribed dosages, dates of initial prescriptions and refills, and name(s) of prescribing physician(s):

Hospitalizations/Surgeries (include dates, complications, adverse reactions to anesthesia and outcomes):

Any relevant medical conditions (Diabetes, Hypertension, Head Traumas, Cardiac Problems, Asthma or other breathing problems, Cancer, etc.

Past Psychiatric History (Mental Health and Dependency or Hospitalization:

Prior Outpatient Therapy (included previous physicians, dates of treatment, previous treatment interventions, response to treatment interventions (including response to medications) and the source of clinical data collected:

Results of recent lab tests and consultation reports:

Family Mental Health or Chemical Dependency History:

_____
_____
_____
_____
_____

Allergies (Adverse reactions to medications / food / etc.):

_____
_____
_____
_____
_____

Military History / Legal History / Marital History:

_____
_____
_____
_____

Substance Abuse History:

Substance	Amount	Frequency	Duration	First Use	Last Use
Caffeine					
Tobacco					
Alcohol					
Marijuana					
Opioids/Narcotics					
Cocaine					
Hallucinogens					
Others					

Informed Consent for Treatment

I _____ agree to consent to participate in behavioral care services offered and provided by the physician, a behavioral healthcare provider. I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training; (2) the scope of license, certification, and training of behavioral healthcare providers directly supervising the services received by the patient.

If the patient is under the age of eighteen (18) or unable to consent for treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and / or legally authorized to initiate and consent on behalf of this individual.

_____

_____

Signature Date

Relationship to Patient:

_____

Medication Consent

L. Wesley Lauterbach has educated me regarding the medication that has been prescribed to (Please check one of the following) _____ Me, _____ My Child, or _____ A person for whom I am the legal guardian and I consent to the administration of this medicine. 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 if the person taking this medication becomes pregnant. I have also been informed of the reason or purpose for which this medication was prescribed.

Patient Name:

_____

Patient / Legal Guardian Signature:

_____

Provider's Signature:

_____

Date: _____

Note:

It is recommended that women who are or may become pregnant, or are breast-feeding, discuss this with their physician **before** taking **any** medication.

It is recommended that patients be educated on reporting all side effects they experience, including, but not limited to, 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, the patient is or has been taking,
2. What food and drug allergies the patient has,
3. What medical conditions the patient has.

HIPAA

I have read and have been given a copy, by request of the Notice of Private Practices for the Franklin Family Psychiatric Care and I acknowledge receipt of these documents.

_____

_____

Signature Date

I am a patient of L. Wesley Lauterbach and I understand I may review the Policies and Procedures Manual for HIPAA compliance to protect my confidential medical information and all processing necessary for my care; at any time.

Disclaimer

The individual Psychiatric Provider treating you in these offices is not employed by any manner by Franklin Family Psychiatric Care. Franklin Family Psychiatric Care does not oversee any care provided by your individual physician. Each and every physician who has any offices in this building is an independent, private practitioner. Franklin Family Psychiatric Care does not evaluate, license or grant privileges to any physician to practice in these offices. If you have any questions please seek further clarification from your physician.

I have read and understood this disclaimer.

_____

_____

Signature of Patient / Guardian / Guarantor Date

Late Charges / No Show Charges

I understand that canceling an appointment without giving twenty-four (24) hour notice may result with a cancellation fee. I the patient / guarantor/ financial responsible party understand that if the patient fails to show for an appointment that a missed appointment charge will be placed on the account.

If you receive a “Late Cancellation” or “No Show” charge on the patient’s statement and want the charge removed, send the statement back to the office with an explanation as to why the appointment was missed so it can be presented to the physician for their approval.

Financial Information

Co-payments are required at the time of services. If you have a financial agreement on file for payment on an outstanding balance this does not exclude you from paying a co-payment at the time of services. If a co-payment is not paid at the time of services the physician does have the right to refuse care. If a patient see’s a physician and the services are not covered by the insurance carrier at the time of services, you the patient / guarantor accept all financial responsibility. This also applies when a provider is not a participating provider on the patient’s insurance, including all government and state insurance policies. It is the patient / guarantor’s responsibility to ensure your services are covered by your insurance policy.

Insurance Changes

If the insurance coverage for the patient changes, a copy of the insurance card (front and back) must be presented to the office either in person or by fax to prevent charges from being denied. If a charge denies for failure to be submitted to a correct insurance carrier within a timely manner, the patient / guarantor /financial responsible party will be responsible for the charges.

Medication and Refills

Please call the office refill line at least three (3) days prior to being out of your medication. This will prevent you from running out of your medication while the physician authorizes a refill or makes a change to your medication where appropriate. Physicians will not be called for refills while out of the office.

If an appointment is cancelled or missed by you and a prescription is needed, there will be a separate charge associated with that prescription refill or written prescription

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Delinquent Accounts

If the financial portion of the account with the physician becomes delinquent and the account is turned over to a collection agency there is a 30% balance mark-up placed on the account to cover the collection agency's fee. This amount will be added to the account balance at the time the account is turned over. This does not include the cost if the account is pursued in court.

_____

_____

Signature of Patient / Guardian / Guarantor Date

We reserve the right to charge for ancillary services according to the fee schedule below.

1. Medical Records require payments of $20.00 for pages 1-5 and $.50 for each additional page prior to release.

2. Prior Authorization form require $20.00 payment prior to completion and submission.

3. Workers Comp, Employment, Disability, and FMLA forms are not completed by this office

4. Phone calls outside of the scheduled appointment time (Beginning 3 months after the initial visit) $10.00 for advice about an existing problem. $20.00 to diagnose a new problem or for repeated calls regarding an existing problem.

5. Refills Requests outside of an office visit.
   If you missed or late cancelled your last appointment, the charge will be $60.
   All other refill requests will be $15.00.

6. Depositions and Court Appearances: The charge will be $500 per hour.

_____

_____

Signature of Patient / Guardian / Guarantor Date

Consent for Release of Confidential Information to Primary Care Physician

Primary Care Physician Name:

_____

Patient Name: _____ SS#

_____

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. **Check and initial <u>all</u> that apply:**

☐ Mental Health Diagnosis

☐ Medication Management Information

☐ Other Mental Health Treatment Information: _____

☐ Other Information Specified Here:

_____

☐ Substance Abuse (SA) Information

For SA Information, this authorization is:

☐ Limited to the following treatment:

_____

☐ Limited to the following time period: _____

OR

☐ I do NOT wish to have information shared with my PCP / Medical Practitioner

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Patient / Guardian / Guarantor Date

_____ _____

Witness Date

Patient Rights and Responsibilities

Our Practice is committed to providing quality health care. It is our pledge to provide this care with respect and dignity. In keeping with this pledge and commitment, we present the following Patient Rights and Responsibilities:

You have the right to:

- A personal clinician who will see you on an on-going, regular basis.
- Competent, considerate and respectful health care, regardless of race, creed, age, sex or sexual orientation.
- A complete, easily understandable explanation of your condition, treatment and chances for recovery.
- The personal review of your own medical records by appointment and in accordance with applicable State and Federal guidelines.
- Confidential management of communication and records pertaining to your medical care.
- Information about the medical consequences of exercising your right to refuse treatment.
- The information necessary to make an informed decision about any treatment or procedure, except as limited in an emergency situation.
- Be free from mental, physical and sexual abuse.
- Humane treatment in the least restrictive manner appropriate for treatment needs.
- An individualized treatment plan.
- Refuse to participate as a subject in research.
- An explanation of your medical bill regardless of your insurance and the opportunity to personally examine your bill.
- The opportunity to file a complaint should a dispute arise regarding care, treatment or service or to select a different clinician.

You are responsible for:

- Knowing your health care clinician's name and title.
- Giving your clinician correct and complete health history information, e.g. allergies, past and present illnesses, medications and hospitalizations.
- Providing staff with correct and complete name, address, telephone and emergency contact information each time you see your clinician so we can reach you in the event of a schedule change or to give medical instructions.
- Providing staff with current and complete insurance information, including any secondary insurance, each time you see your clinician.
- Signing a "Release of Information" form when asked so your clinician can get medical records from other clinicians involved in your care.
- Telling your clinician about all prescription medication(s), alternative, i.e. herbal or other, therapies, or over-the-counter medications you take.
- Telling your clinician about any changes in your condition or reactions to medications or treatment.
- Asking your clinician questions when you do not understand your illness, treatment plan or medication instructions.
- Following your clinician's advice. If you refuse treatment or refuse to follow instructions given by your health care clinician, you are responsible for any medical consequences.
- Keeping your appointments. If you must cancel your appointment, please call the clinic at least 24 hours in advance. There is a $60 charge for missed appointments and appointments cancelled without 24 hour notice.
- Paying copayments at the time of the visit or other bills upon receipt. You will be asked to reschedule your appointment if you cannot pay your co-pay at the time of service.
- Following the office's rules about patient conduct; for example, there is no smoking, eating, or drinking in our office.
- Respecting the rights and property of our staff and other persons in the office.

By signing below you acknowledge you have read, understand and agree to these rights and responsibilities.

_____ _____

_____

Signature of Patient / Guardian Date