MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

New Patient Registration

Name:_____ Date of Birth:_____
Address:_____ SSN (last 4 digits)_____
_____ Phone (M): (_____) _____-_____
Email:_____ Phone (H): (_____) _____- _____

Please advise our office of any changes in your contact information. Email to be used for appointment reminders.

Primary Care Physician: _____ Phone: (_____) _____ - _____
Other physicians (OB/Gyn, neurologist etc.): _____ Phone: (_____) _____ - _____
Therapist: _____ Phone: (_____) _____ - _____
Pharmacy: _____ Phone: (_____) _____ - _____

Current Medications:_____ Allergy:_____
_____ _____
_____ _____
_____
Previous psychiatric medications: _____
_____

Emergency Contact Name: _____ Relationship:_____
Emergency Contact Number: _____

What brings you to see us today? _____
How did you hear about Mental Wellness Clinic?_____

I consent Mental Wellness Clinic to obtain and/or disclose healthcare information to/from the healthcare providers listed above.
I voluntarily consent to treatment and understand that I have the right to make informed decisions regarding my care.
I understand that I am responsible for payment for psychiatric services rendered at the time of my appointment.
I am responsible for the full cost of any appointments unless I give notice of cancellation at least two full business days prior to appointment.
I acknowledge that I have received or declined the Notice of Privacy Practices. I understand that this Notice is available for me to keep.

_____ _____ _____
Patient Signature: Printed Name: Date:

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

Policies and Procedures

INITIAL CONSULTATION – CONSENT TO ENGAGE IN TREATMENT

All initial appointments at Mental Wellness Clinic are consultation appointments. Providers will perform a full evaluation and give feedback regarding the evaluation and any recommended treatment plan. The consultation is designed so that the provider and patient can determine by the end of the initial appointment if they would like to continue working together. If so, the provider at Mental Wellness Clinic will become the patient's treating psychiatrist. If at any point during treatment, the provider or the patient determines that the patient would be better served by receiving treatment from a different provider, this will be discussed and referrals will be provided to the patient.

CONFIDENTIALITY

All information shared with Mental Wellness Clinic will be kept completely confidential as mandated by HIPAA. Providers may share certain information to a third party only with the express written agreement and consent of the patient AND if the provider deems that doing so is in line with the patient's treatment plan. There are some situations in which providers at Mental Wellness Clinic may be legally required take action that could include revealing some information about the patient's treatment. Examples of such situations include imminent risk/threat of self-harm (patient), imminent risk/threat of harm to others, and child or elder abuse. Please refer to Mental Wellness Clinic Privacy Practices document for full details on all privacy practices. A copy of privacy practices is given to all new patients and is also available upon request.

BILLING/PAYMENTS

Payment is due in full at the time of service via credit card or cash. We accept Visa, MasterCard, American Express and Discover. Mental Wellness Clinic is an "out-of-network" provider and is unable to directly file claims with insurance as a form of payment. Patients with health insurance will need to pay out-of-pocket at the time service and are encouraged to submit claims to their insurance and utilize any out-of-network benefits. All patients will be provided with a specialized invoice (receipt) at the time of payment that contains all information necessary to submit claims for out-of-network reimbursement.

APPOINTMENTS/CANCELLATIONS

Patients are financially responsible for all services scheduled with Mental Wellness Clinic. If a patient would like to cancel an appointment, notice must be given within 2 full business days (48 hours excluding weekends and holidays) prior to the appointment. Any cancellations received after this time will be subject to charge for the full session. Please note that insurance plans do not reimburse for missed appointments. Patients arriving late to appointments will be subject to charge for the full session. Patients who arrive with less than 10 minutes remaining in the appointment will not be seen. The patient will be charged for the full session and a new appointment will need to be scheduled.

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

MEDICATION REFILLS

When calling about a refill, please leave your name, date of birth and your phone number, along with the medications requested, their dosages and the phone number of your pharmacy. If accepted by the provider, please allow 2-3 business days for medications to be refilled.

CONTACT INFORMATION

Contact your provider at Mental Wellness Clinic at 240-753-0095 and your call will be returned at our earliest convenience within one business day.

In the event of a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.

I have read and understood the policies as stated above. I have had the opportunity to discuss my questions and concerns. I agree to comply with the office policies and procedures as noted.

_____ _____

Patient Signature Date

_____

Printed Name

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

Credit Card Authorization Form

It is the policy of Mental Wellness Clinic to keep a credit card on file for patients.

I, _____, herby authorize Mental Wellness Clinic to keep this form and my signature on file and charge my credit card the full amount for any of the following services:

1. Initial evaluation
2. Follow-up appointments for medication management, psychotherapy or other related services.
3. Appointments that I do not cancel prior to one full business day of the scheduled appointment
4. Additional and/or future services that I verbally approve

Cardholder Name: _____

(name as it appears on credit card)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ Exp Date: _____

Credit Card Billing Address: _____ CVV Code: _____

_____

I agree not to dispute charges for any of the terms outlined above.

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written communication with my provider at Mental Wellness Clinic.

_____ Date: _____

Cardholder Signature

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

Medical Information Release Form

Patient name: _____ DOB:_____

I authorize Mental Wellness Clinic to do the following with my protected health information:

☐ Disclose and/or obtain protected healthcare information to/from individuals/entities listed below

☐ Provide a complete copy of my healthcare records to those individuals/entities listed below

☐ Provide only part of my health care records, limited to the following information, to those individuals/entities listed below:

Name of Person/Entity: _____
Address: _____
_____
Phone: _____
Fax: _____

Name of Person/Entity: _____
Address: _____
_____
Phone: _____
Fax: _____

I understand that the medical information released may contain information related to HIV/AIDS status, sexually transmitted diseases, mental health and drug or alcohol abuse.

_____ _____
Patient signature Date

_____
Printed Name

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

Consent to Electronic Communications

I authorize Mental Wellness Clinic to E-mail/text me information or documents which contain patient identifiers and/or sensitive health information (i.e., answer questions that I have, send invitations for telepsychiatry appointments, completed insurance forms or disability forms, letters for work or school, lab results, bills or invoices, etc.) only after I have verbally discussed this with my provider at Mental Wellness Clinic.

I acknowledge that I have been provided with the Mental Wellness Clinic Notice of Electronic Communications Practices (see below). By signing this consent form, I accept the following:

1. I understand the risks associated with communication via E-mail between Mental Wellness Clinic and me, and I consent to the conditions and guidelines outlined in the Mental Wellness Clinic Notice of E-mail Practices, as well as any other instructions that Mental Wellness Clinic may impose regarding communication.

2. I understand that any E-mail voluntarily sent by me to Mental Wellness Clinic will not be encrypted and there for the confidentiality of such communications may be breached by a third party.

3. I understand that I may alter these communication permissions at any time by updating this consent form and that only the most recent consent form signed will be in effect.

5. I understand that this consent will remain in effect until terminated in writing either by myself or by Mental Wellness Clinic.

6. I understand that if I have any questions, I may inquire with Mental Wellness Clinic.

The cell phone number that I authorize to receive text messages is: _____.

The email that I authorize to receive email messages is_____.

_____ _____

Patient signature Date

_____

Printed Name

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

Notice of Electronic Communications Practices

Mental Wellness Clinic may send superbills to patient's e-mail via an encrypted email. It is our general policy that all other communications between patients and providers at Mental Wellness Clinic be conducted either in person or over the phone to ensure and maintain HIPAA standards of confidentiality. However, there are times when a patient may wish to use e-mail or text messaging as an alternative form of communication. The patient has a right to request the use of e-mail or text messaging as an alternative form of communication as long as the patient is made aware of the risks associated with using e-mail or text messaging.

RISK OF USING E-MAIL/TEXT MESSAGING

The transmission of patient information by e-mail or text messaging has several risks that patients should consider before the use of e-mail. These include, but are not limited to, the following risks:

1. E-mail/text messages can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. E-mail/text messages senders can easily misaddress an e-mail and send the information to an undesired recipient.
3. Backup copies of E-mail/text messages may exist even after the sender and/or the recipient has deleted his/her/their text.
4. Employers and online services have a right to inspect E-mail/text messages sent through their company systems.
5. E-mail/text messages can be intercepted, altered, forwarded, or used without authorization or detection.
6. E-mail/text messages can be used as evidence in court.
7. E-mail/text messages may not be secure, and therefore the confidentiality of such communications may be breached by a third party.

CONDITIONS FOR THE USE OF E-MAIL/TEXT MESSAGING

Mental Wellness Clinic cannot guarantee but will use reasonable means to maintain the security and confidentiality of all information sent and received. Mental Wellness Clinic is not liable for improper disclosure of confidential information that is not caused by Mental Wellness Clinic's intentional misconduct. Patients must acknowledge and consent to the following conditions:

1. E-mail/Text messaging is not appropriate for urgent or emergency situations. Mental Wellness Clinic cannot guarantee that any particular e-mail or text messaging will be read and responded to within any specific timeframe.
2. As Mental Wellness Clinic provides mental health services, communication via e-mail or texting outside of appointment scheduling will need to be discussed and will be used on a case-by-case basis. In general, it is the policy of Mental Wellness Clinic not to use e-mail or text messaging to discuss or address clinical issues (i.e., changes in symptoms, problems with medications).
3. All clinically relevant e-mails or messaging will be printed and filed into the client's medical record per the physician's discretion.
4. Mental Wellness Clinic will not forward patient-identifiable e-mails or text messaging without the patient's written consent, except as authorized by law.
5. Mental Wellness Clinic is not liable for breaches of confidentiality caused by the client or any third party.
6. Any e-mail or text messaging consent signed by the patient will remain in effect until terminated in writing either by myself or by Mental Wellness Clinic
7. In the event that the patient does not comply with the conditions herein, Mental Wellness Clinic may terminate the patient's privilege to communicate by e-mail or text messaging with Mental Wellness Clinic

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Responsibilities

Your protected health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination, test results, diagnoses and treatments. It also includes payment information related to your care. The law requires us to keep your health information private in accordance with this Notice of Privacy Practices. We are also required to provide you with a copy of this document, which contains our privacy practices, our legal responsibilities, and your rights concerning your health information.

Permitted Uses and Disclosures

Under federal law, we may use and disclose your health information without authorization for treatment, payment or health care operations. Examples of such potential uses or disclosures are provided below:

• Treatment

Your health information may be used by or disclosed to any physicians or other health care providers involved with the medical services being provided to you. We may also use your health information to manage or coordinate your treatment.

• Payment

Your health information may be used or disclosed in order to collect payment for the medical services provided to you.

• Health Care Operations

Your health information may be used or disclosed as part of our internal health care operations, such as quality of care audits, training programs, accreditation, certification, licensing or credentialing activities.

Other Uses and Disclosures without Authorization

While the following disclosures can be made without your consent or authorization, we will make our best effort to inform you when a disclosure is being made or there is an intention to do so.

• Abuse, Neglect, or Domestic Violence

As required by law, we may disclose your health information to report suspected abuse, neglect, or domestic violence.

• Judicial and Administrative Proceedings

We may disclose your health information in the course of a judicial or administrative proceeding, in response to a subpoena or other orders required by law.

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

• Notification

We may use or disclose your health information to notify a family member or other person identified by you who is involved in for your care about your location, about your general condition, or about your death. We will provide you an opportunity to object before disclosing any such information.

• Public Safety

We may disclose your health information for public health purposes such as a serious and imminent threat to the health or safety of a person or the public.

• Required by Law

We may be required by federal, state, or local law to disclose your health information.

• Third party

We may disclose your health information to third parties with whom we contract to perform services on our behalf. If we do so, we will have an agreement with them to safeguard your information.

We will not disclose your health information for any reasons, except those described in this Notice of Privacy Practices, unless you provide us with written authorization to do so. We may request an authorization to use or disclose your health information for any purpose, but you are not required to give authorization as a condition of your treatment. Any written authorization from you may be revoked by you in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Rights

You have the following rights with respect to your protected health information:

• Requesting Restrictions

You have the right to request a restriction on limiting our use and disclosure of your health information. We are not required to agree to your request, but if we do agree to it, we will abide by your request except as required by law, in emergencies or when the information is necessary to treat you. To request a restriction, it must:
1) be in writing 2) describe the information that you want restricted 3) state if the restriction is limited to use or disclosure and 4) state to whom the restriction applies.

• Confidential Communications

You have the right to request that we communicate with you about your health information in a particular way or at a certain location, to maintain your confidentiality. To request confidential communication, it must: 1) be in writing and 2) specify how or where you wish to be contacted. We will accommodate all reasonable requests. You do not have to give a reason for your request.

• Inspect and Copy

You have the right to inspect and obtain a copy of your health information. To request to inspect or obtain a copy of your health records, it must be in writing. We may charge a fee for record retrieval, copying costs, mailing and other supplies.

MentalWellnessClinic

11404 Old Georgetown Rd, Suite 203
North Bethesda, MD 20852
Tel # 240-753-0095 I Fax # 973-695-3653

• Amendment of Health Information

You have the right to request amendment of your health information, if you believe that it is incorrect or incomplete. To request an amendment, it must: 1) be in writing and 2) include a reason to support your amendment request. Your request may be denied if it was not created by us, if we believe that the information is complete and accurate or if the information is not part of the medical information that you would be permitted to inspect or copy.

• Accounting of Disclosure:

Under federal law, you have the right to request a list of the disclosures that we have made of your health information over the previous six years. This right applies to disclosures other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period. To request an accounting of disclosure, it must be in writing.

• Paper Copy of This Notice

You have the right to keep a paper copy of this Notice of Privacy Practices.

• File a Complaint

If you believe that your privacy rights have been violated, you may file a complaint directly with us in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

This Notice of Privacy Practices and its terms may be revised as permitted or required by law. Mental Wellness Clinic has the right to make the revised notices effective for information that we already have about you, as well as information we obtain in the future. The updated Notice of Privacy Practices will be provided to you in paper copy.

I acknowledge that I have received the Notice of Privacy Practices. I understand that this Notice is available for me to keep.

_____ _____

Patient signature Date

_____

Printed Name