Date of Appointment: ____________________

Patient Information: *Please Print*

Last ____________________ First ____________________ MI __ Male/Female
Address____
City ________________________ State ______ Zip________ Single/Married/Div/Widow
Home Phone ____________ Cell/Alternate ____________ Email __________________
Patient's Social Security # _____________ DOB _________________
Employer _________________________________ Work Phone # ____________________

Emergency Contact __________________________ Phone # _______________________

Primary Care Physician _______________________ Phone # ________________________

Responsible Party (If Patient is Minor):

Name __________________________________ Relationship to Patient_______________
Address _____________________________City ____________ State ______ Zip ______
Daytime Phone (In case of Emergencies) ____

Insurance Information

Primary Insurance _____________________________ ID # _______________________
Subscriber Name _______________________________ Relationship to Pt _____________

Secondary Insurance ___________________________ ID # _______________________
Subscriber Name _______________________________ Relationship to Pt _____________

Pharmacy Name: ______________________________ Phone # ____________________
Address: ____________________________________

I hereby authorize treatments and/or consultation for the above patient by Comprehensive Psychological Services. I also authorize release of records to any agency involved in the payment for treatment of this patient and assign all benefits to Comprehensive Psychological Services. I, the undersigned, agree to pay the amount due and if not paid at the time service is rendered, I shall be responsible for all costs of collections, including attorney/legal fees.

Signature ____________________________________ Date ________________________

Contact Method For Appointment Reminders:

___ Text ___ Phone call ___ Email ___ Do not Contact

Practice Cancellation / No-Show Policy

Thank you for choosing Comprehensive Psychological Services to assist you with your needs. To ensure appointment times are available when needed, either for therapy or medication management, it is important that some guidelines are established and maintained.

When an appointment is made for therapy or medication management, you have filled a time slot that no one else can occupy. If an issue arises regarding your appointment and unable to keep the scheduled time, we ask that you contact the office at (757) 547-9007, to cancel at ***minimum of 24 hours*** prior to the appointment time. Comprehensive Psychological Services' phones are manned by the Front Office from 9:00 am to 5:00 pm daily, then the answering service will be in place. You can always leave a voice mail confidentially 24 hours a day, 7 days a week.

If there is an emergency on the day of your appointment that does not allow you to keep your appointment, please call the office as soon as possible to let us know that you will not be able to keep the scheduled appointment. You may be asked to give the reason specifically, for charting reasons.

If an appointment is cancelled less than a 24-hour notice, a fee of $40.00 will be charged to your account. ***Your insurance company does not pay this fee.*** It is paid directly out of your pocket. Please understand that it is usual and customary to charge a fee if a business that provides services is not given a minimum of a 24-hour notice for cancellation of an appointment.

By signing below, you, the responsible party, are agreeing to the above terms of paying the $40.00 cancellation/no-show fee.

Name of Patient ______________________________________ Date ____________________

Responsible Party Signature ____

Witness Signature ____________________________________ Date ____________________

Statement of Fee and Method of Payment

This form is utilized to establish a clear understanding regarding the details of your financial account with our practice. Please read it entirely and ask any questions you may have. Your signature means you understand and agree with the contents of this form.

Name of Patient ___________________________________ SSN _______________________
Name of Responsible Party _________________________ Relationship to P/t ______________

I, __________________________________, agree to be responsible for payment, in full, of charges for professional services that have been provided to the above-named patient by Comprehensive Psychological Services. I also understand and agree to the following fees and method of payment:

a. If desired, Comprehensive Psychological Services shall file insurance claims on behalf of the Patient for services provided. Insurance payment shall be made directly to the Practice. Should the insurance carrier remit payment to the Patient or Responsible Party, the Responsible Party agrees to promptly forward payment to the Practice. The Patient or Responsible Party will supply to the practice any insurance forms that may be necessary to expedite the filing process monthly.

b. The Patient or Responsible Party shall pay the estimated "co-insurance payment" at the time of each visit. This is the amount, which is estimated as not being covered by the Patient's insurance.

c. The Responsible Party shall pay any outstanding balance that is not covered by insurance (e.g. deductible, co-payments, denied claims). The Patient or Responsible Party, not the insurance company, is ultimately responsible for the payment of the service provided.

d. As a courtesy, Comprehensive Psychological Services' staff will make phone calls to remind you of appointments. Calls are made to your home, cell, or work number and messages are left, either by voice mail or with person answering the phone. Please initial here if you ***Do Not Want Us To Call To Confirm/Remind of Appointment***. ______________

e. I hereby authorize Comprehensive Psychological Services and/or their designates to provide medical and/or mental health treatment, release information pertaining to treatment for insurance purposes, and to receive direct insurance payments for professional and hospital treatment otherwise payable to me for services provided. I understand that I am financially responsible for payment for all services at the time they are provided unless other prior arrangements have been established in writing. In the event that my account must be forwarded to an outside agency or attorney for collection, I understand that I am responsible for all costs of collection, including but not limited to, court cost and interest.

Patient or Responsible Party Signature ____________________________________

Notice of Privacy Practice

Effective January 1, 2011

Under new regulations governing your privacy and medical information, this notice provides information to you about how your medical information may be used and disclosed and about how you can get access to your information.

Just as we make every effort to protect your confidentiality regarding treatment, we are committed to protecting the privacy of your medical records. We may use your information to obtain payment for services and administrative purposes. We may also disclose your information without your consent in certain circumstances such as emergencies or as required by law. Any other circumstances we will request your written authorization to disclose information. If you sign a release to disclose information you may specify what information you wish to have disclosed and you may revoke the release at any time to prevent future disclosure of information.

You have certain rights regarding your medical records.

You, as the patient, have the right to view and make copies of your medical records. If the patient is a minor, then a parent or guardian has the right to view the minor's records. There are some records, which you do not have the right to. Under federal law you may not inspect or copy the following: psychotherapy notes, information regarding civil or criminal action, and information that is forbidden to be disclosed under law.

You, as the patient, have the right to amend your records. If you believe that any information in your records is incorrect you may amend those records by submitting a written statement correcting the items, you feel are incorrect. We will add your request to your records; however, we have the right to deny amendment of your medical records. If you disagree with our denial, you have the right to submit a written appeal.

You, as the patient, have the right to know when we release information from your medical records. Medical records remain confidential unless you have signed a written release of information to release specific parts of your records or your entire record. Any restrictions to releasing information must be in writing on the release of information form you sign to release the information initially. There are two (2) exceptions to this: if your records are subpoenaed by a court of law in a legal matter or if you initiate litigation against your therapist then your medical records can be shared with an attorney in the therapist's defense. If the medical records of a minor child are requested by a parent or subpoenaed by a court and it is the treating therapist's professional opinion that releasing those records to the requesting individual could be harmful to the patient (minor) then your therapist has the right to request legal action to prevent release of those records.

Insurance companies may require us to submit certain information with request for payment/claim. Information such as date of service, diagnostic code, id number is submitted. If your insurance company requests further information to process payment, your signature on the new patient information form consents to do so.

Understand that on occasion we are asked to supply medical records to other professionals. We also receive medical information from other professionals. We will do everything within our ability to protect the privacy of your medical records.

Our therapists are willing to discuss your medical records with you. Most exchanges of information between professionals can occur with a summary letter or via telephone.

You may also notice some changes in our office to further insure your privacy and confidentiality.

-When your therapist or our office staff greets you, we will use your first name only.
-We request that only one person be at the reception window at a time. If there is a line, please move away from the window until the person in front of you has completed their business and the receptionist will then attend to you.
-Any discussion of information of a personal nature such as financial arrangements, insurance, medications, etc. will be conducted in an office away from the waiting room.
-No papers or documentation with patient information on it will be visible to anyone other than the patient.

<u>You have the right to obtain a written copy of this privacy notice.</u> If you would like a copy of this notice, please request it when you sign it. Otherwise, your signed copy will become part of your medical record.

If you have any questions about this notice or the policies of Comprehensive Psychological Services regarding privacy of your information please contact our privacy officer, Robert Velasquez – Practice Administrator, at the below address (2117 Smith Ave)

I ____ acknowledge that I have read the above information regarding my rights to privacy while receiving services in this office. I have also received/ denied a copy of this document.

Printed Name: ________________________ **Signature:** ___________________________

Date: ________________________

TELEPSYCHIATRY PATIENT CONSENT FORM

In order to receive telepsychiatry services from Comprehensive Psychological Services, you must be a **Virginia State Resident**.

Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a patient that are not in the same physical location. These services may also include electronic prescribing, appointment scheduling, communication via email or electronic chat, electronic scheduling, and distribution of patient education materials.

The potential benefits of telepsychiatry are:

- Reduced wait time to receive psychiatric care.
- Avoiding the need to travel to a psychiatrist.

The potential risks of telepsychiatry include, but are not limited to:

- A telepsychiatry session will not be exactly the same, and may not be as complete as a face-to- face service.
- There could be some technical problems (video quality, internet connection) that may affect the telepsychiatry session and affect the decision making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face to face visit, but not in a telepsychiatry session, may result in errors in judgment.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Comprehensive Psychological Services utilizes software that meets the recommended standards to protect the privacy and security of the telepsychiatry sessions. However, the service cannot guarantee total protection against hacking or tapping into the telepsychiatry session by outsiders. This risk is small, but it does exist.

Alternatives to the use of telepsychiatry:

- Traditional face-to-face sessions.

I understand that I have the following rights with respect to telepsychiatry:

(1) I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.

(2) The laws that protect the confidentiality of my medical information also apply to telepsychiatry. As such, I understand that the information disclosed by me during the course of my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim; and where I make my mental or emotional state an issue in a legal proceeding.

I also understand that the dissemination of any personally identifiable images or information from the telepsychiatry interaction to researchers or other entities shall not occur without my written consent.

(3) I understand that there are risks and consequences from telepsychiatry, including, but not limited to, the possibility, despite reasonable efforts on the part of my psychiatrist, that: the transmission of my medical information could be disrupted or distorted by technical failures; the transmission of my medical information could be interrupted by unauthorized persons; and/or the electronic storage of my medical information could be accessed by unauthorized persons.

In addition, I understand that telepsychiatry based services and care may not be as complete as face-to- face services. I also understand that if my psychiatrist believes I would be better served by another form of psychiatric services (e.g. face-to- face services) I will be referred to a psychiatrist who can provide such services in my area. Finally, I understand that there are potential risks and benefits associated with any form of psychiatry, and that despite my efforts and the efforts of my psychiatrist, my condition may not be improve, and in some cases may even get worse.

(4) I understand that I may benefit from telepsychiatry, but that results cannot be guaranteed or assured.

(5) I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia Law.

Patient's Responsibilities

I will not record any telepsychiatry sessions without written consent from my provider. I understand that my provider will not record any of our telepsychiatry sessions without my written consent.

I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer that is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I must be a resident of the State of Virginia to be eligible for telepsychiatry services from Comprehensive Psychological Services.

I understand that my psychiatrist determines whether or not the condition being diagnosed and/or treated is appropriate for a telepsychiatry encounter.

I understand that if the telepsychiatry session does not achieve everything that is needed, then I will be given a choice about what to do next. This could include a follow up face-to- face visit, or a second telepsychiatry visit.

I can change my mind and stop using telepsychiatry at any time, including in the middle of a video visit. This will not make any difference to my right to ask for and receive health care.

Patient Consent To The Use of Telepsychiatry:

I hereby consent to engaging in telepsychiatry with Comprehensive Psychological Services as part of my psychiatric evaluation and treatment. I understand that "telepsychiatry" includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I have read and understand the information provided above regarding telepsychiatry.

Name of Patient:

First Name MI Last Name

Consent to Receive Text Messages from Comprehensive Psychological Services

By signing below, I authorize Comprehensive Psychological Services through its vendor (third party) texting services to contact me via SMS text message to serve me better. Comprehensive Psychological Services will send me text messages regarding timely reminders of appointments with a provider. I know that I am under no obligation to authorize Comprehensive Psychological Services to send me text messages.

I may opt out of receiving communications from Comprehensive Psychological Services at any time by contact the front office at (757) 547-9007 or email: cpsadmin@comppsych.net.

Name of Patient:

First Name MI Last Name

Signature: ____

Date: ________________________

Controlled Substance Contract

Patient Responsibility

Instructions: Place initials in the box below each statement.

1) I agree to take any controlled substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my controlled substances provider.

2) I will not take controlled substances written by another provider or specialist unless I have notified my provider prior to filling the prescription.

3)I agree to safekeeping my controlled substance prescriptions and medications. I understand that lost , misplaced, or stolen prescriptions or medications will not be replaced.

4)I will bring in all my controlled substance medications in their original pill container to every appointment.

5)I will bring in all controlled substance medications in their original pill for random pill counts within 24 hours of when requested.

6) I will NOT combine controlled substance medication with consumption of alcohol. Any UDS/ Serum that is positive for both controlled substances and alcohol will be considered a violation of this contract.

7)I will NOT combine any controlled substances medications with illegal/ street/recreational drugs. Any UDS/serum drug screens that is positive for both prescribed controlled substances and illicit substances will be considered a violation of this contract.

8)I will be responsible for making and keeping appointments for controlled substance refills as scheduled . I understand that no refills will be written outside of my appointment and I will not contact the office for refills of these medications.

9)I will be responsible for having a working phone number/email address, which the office will use to contact me about pill counts or random drug screens. I understand that once notified by the office, either directly or by voicemail/email, I will have 24 hours to report, or inability to do so will result in a violation of this contract. I understand that it is my responsibility to monitor my voicemail an email.

10) I understand that not all insurances cover the cost of drug screening and that I may be responsible for part or the entire bill. I understand that lack of insurance coverage DOES NOT exempt me from required drug screenings.

11)I understand that I will not receive any controlled substances until my provider has been able to review my medical record. If I am a new patient, I understand that it is my responsibility to ensure my medical records have been obtained from my previous provider.

12) I will not lie or tell misleading information to my provider or any of the CCPS staff.

13) I will not get angry or make threatening remarks in an attempts to get controlled substances.

Consequences of NOT adhering to any part of this contract:

1) Our office/provider will no longer:

A. Prescribe any controlled substance for you. It will be at provider discretion to decide if a taper of medication will be given.

B)May stop providing medical care for you.

C) May refer you for drug abuse treatment

Consequence of NOT signing this contract:

We will not prescribe controlled substances for you.

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to controlled substances if the reason for discharge was a violation of this contract.

Signature:

Patient Name

Patient DOB

AUTHORIZATION FOR RELEASE OF
MEDICAL/HEALTH RECORD INFORMATION

Patient Name: ________________ Date of Birth: ___________ Phone: _____________

Address: ______________________ City/State/Zip: ______________________

If patient is under 18 years of age Parent/Guardian/ In Loco Parentis:

Name: ________________________ Phone: _____________

Address: ______________________ City/State/Zip: ______________________

Please Note: Copy Fee May Be Charged For Medical Record

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility/Provider: ___________________ Facility/Provider Phone: ___________________

Facility/Provider Address: __________________ Facility/Provider Fax: ___________________

City/State/Zip: ___________________

Dates and Type of Information to disclose:	**Purpose of disclosure is:**
☒ All records	☐ Release of Information
☐ Dates Other: ________________	☒ Obtain Information
☐ Specific Information Requested:	☒ Exchange Information
____________________________	☐ Other: _________________

_____ Diagnosis _____ Psychological Test Results _____ Psychiatric Evaluation/Medical History

_____ Dates of Treatment _____ Progress Notes

Restrictions: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid for the release of medical information dated prior to and including the date on this authorization unless dates are specified.

This information may be disclosed and used by the following individual:

Release to: **Comprehensive Psychological Services**

Address: **2117 Smith Ave, Ste B**

City/State/Zip: **Chesapeake, VA 23320**

Fax: **(757) 548-1928/(757) 786-2805** Phone: **(757) 547-9007**

Staff Only
Please Mail: ____ **Please Fax:** _X_

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Front Office personnel. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. ***Unless otherwise revoked, this authorization will expire on the following date, event, or condition: __________. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.***

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

______________________________________ ____________________
Signature of Patient/Parent/Guardian or Authorized Representative ***Date***

______________________________________ ____________________
Signature of Comprehensive Psychological Services Staff ***Date***