CHISOVEREIGN

P: (703)-246-0011

F: (703)-246-0012

www.ChiSovereign.com

WELCOME TO CHISOVEREIGN!

Thank you for scheduling an evaluation appointment with us. Our mission is to provide you with the best treatment available. Our treatment is tailored towards an individual's specific needs and delivered within a collaborative, compassionate, non-judgmental therapeutic relationship.

The purpose of this initial consultation is to collect basic information about you and your clinical concerns. It is our goal to formulate an initial diagnosis and treatment plan during this session but sometimes this requires more than one visit.

There are a few steps that you can take to prepare for the consultation:

~ Prior to your appointment, we ask that you complete the patient registration. Arrive 20 minutes prior to the scheduled appointment time with your completed paperwork and the other required items noted below.

~ Call your insurance and verify if you need any authorization for your first visit. When calling please specifically ask if your coverage requires Outpatient Mental Health authorization, your copay or coinsurance.

~Please bring these items to your first appointment.

- New Patient registration -completed
- Insurance card & authorization information
- Photo ID/Driver's License (if a child, the parents' ID) - Preferred
- Preferred Pharmacy Name, Address & Number

If you do not bring the insurance related items, you will be responsible for the full payment until we have the information required for insurance filing.

~ Prepare a list of prior and current medications, dosage, effectiveness or side effects; bring copies of psychological testing reports, and your family history of psychiatric conditions or treatments.

~ It is also helpful if you think about what you would like to accomplish with your treatment.

Please be sure to review the following office policies.

If you have any questions, contact us at 703-246-0011

Thank you and we look forward to meeting you at your appointment.

CHISOVEREIGN

NEW PATIENT FORM

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Date _____ (Please Print) Home Phone _____

PATIENT INFORMATION

Name _____ Soc. Sec # _____
Last Name First Name Initial

Address _____

City State Zip _____

Email _____

Sex M / F (circle one) Age _____ Birthdate _____ Single Married Widowed Separated Divorced (circle one)

Patient Employed? _____ Occupation _____

Business Address _____ Business Phone _____

Whom may we thank for referring you? _____

In case of an emergency who should be notified. Name _____ Phone _____

Preferred Pharmacy Name / Address _____

GUARANTOR INFORMATION

Name _____
Last Name First Name Initial

Address _____

City State Zip _____

Home Phone: Cell Phone: _____

Relationship to Patient _____

DOB: Soc. Sec # _____

PRIMARY INSURANCE

Policyholder name: _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec # _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone _____ Occupation _____ Employer _____

Business Address _____ Business Phone _____

Insurance Company _____

Contact # _____ Group # _____ Subscriber # _____

Name of other dependents covered under the plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes / No (circle one)

Subscriber Name _____ Relation to patient _____ Birthdate _____

Address (if different from patient) _____

City _____ State _____ Zip _____

Phone _____ Occupation _____ Employer _____

Business Address _____ Business Phone _____

Insurance Company _____ Soc. Sec # _____

Contact # _____ Group # _____ Subscriber # _____

Name of other dependents covered under the plan _____

REFERRAL/AUTHORIZATION INFORMATION

AUTHORIZATION # _____ # OF VISITS _____

Many insurance carriers require you to obtain a referral and/or authorization for mental health services. The responsibility of obtaining a referral is that of the patient or the patient's guardian for your first appointment (only exception is Tricare). Failure to get an initial authorization may result in non-payment from the insurance. You will be responsible for any services denied by your insurance carrier due to not obtaining an initial authorization.

_____ INITIAL

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____

Name of Insurance Company

And assign directly to **CHISOVEREIGN, PLLC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **CHISOVEREIGN, PLLC** to release all information necessary to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date

POLICIES AND PROCEDURES

PRESCRIPTION REFILLS: Refills not made during scheduled visits may be requested via email, fax, or phone. If you choose to utilize our prescription refill service, you will be charged an administrative fee of $25 that will not be billed to or reimbursed by your insurance carrier.

LATE CANCELLATIONS/MISSED APPOINTMENTS POLICY: We understand there are times when you must miss an appointment due to emergencies or obligations to work and family. If an appointment is not cancelled at least 24 hours in advance, you personally will be charged a **$60.00** cancellation fee, (you, not your insurance company). If you fail to show or call, you will be charged an **$80.00** no show fee. Should you cancel less than 24 hours prior to, or fail to show up for your scheduled initial evaluation, you will be held responsible for evaluation fee

FEES: At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic/treatment procedures. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section below and if we participate with your health plan.

INSURANCE COVERAGE: Insurance companies and employer plans vary significantly in how they administer mental health benefits. We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. Chisovereign will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made an error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available.

NOTIFICATION OF CHANGES
We ask that you notify our office immediately of changes in the following information:
~ Name, address, or phone number changes
~ Change in Insurance Carrier
~ Change in Primary Care Physician
~ Change in marital status

RETURNED CHECKS: There is a $25 (Twenty-five) charge for any returned check from your bank.

I understand and agree to abide by the above policies and procedures:

Patient Signature: _____ Date: _____

CREDIT CARD AUTHORIZATION

I, _____, authorize the office of CHISOVEREIGN, PLLC to process a charge on my credit card for fees not paid directly to office staff in cash or via check for insurance deductibles, copayments, missed appointments, requested letters of administrative services or medical records.

(CIRCLE ONE)

MasterCard, Visa, Discover, American Express

Account Number _____ Expiration Date _____

Exact name on card: _____

Credit Card billing zip code _____

Patient Signature: _____ Date: _____

MEDICAL INFORMATION

1. Describe your present concerns. Be specific

2. Current Medication (name, dosage, start date);

_____

_____

3. List Allergies:

_____

4. List past and present medical problems:

_____

_____

_____

5. List previous hospitalizations:

_____

_____

_____

6. Do you smoke?_____If yes, how many packs per day?_____Years? _____

7. Do you drink alcohol/use drugs?_____If yes, how yes how often_____times per week
Number of beers per week_____Cocktails_____Wine glasses____Other_____

8. Do you exercise?_____If yes, how often? _____
What kind of exercise? _____

9. Does anyone in your family have the following? If yes, please specify relationship:

Heart Disease _____
Anxiety Disorders _____
Hypertension_____
Gynecological Disorders _____
Strokes_____
Headaches_____
Muscle Disorders _____
Urological Disorders _____
Major Depression _____
Dementia _____

Joint disorders _____
Thyroid disorders _____
Gastrointestinal disorders _____
Diabetes_____
Weight disorders_____
Blood disorders_____
Alcohol/Drug Abuse _____
Cancer_____
Bipolar Disorder _____
ADHD _____
Schizophrenia _____

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LIMITS OF CONFIDENTIALIITY

Contents of all sessions are considered to be confidential. Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a patient discloses intentions or a plan to harm another person, we are required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, we are required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults
If a patient state or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, we are required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
We are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor patients have the right to access the patients' records.

Insurance Providers (when applicable)
Insurance companies and other third-party payers are given information that they request regarding services to patients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Signature of Patient (Patient's Parent/Guardian if under 18)

Date of Signature___/___/___

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NOTICE OF PRIVACY PRACTICES

(Effective Date of Notice - January 1, 2014)

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.

A. This section explains your rights and some of our responsibilities to you.

Get an electronic or paper copy of your medical record.

You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.

We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

You can ask us to correct health information about you that you think is incorrect or incomplete.

We may say "no" to you request, but we will tell you why in writing within 60 days.

Request confidential communications.

You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.

We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

You can ask us not to use or share certain health information for treatment, payment, or our operations.

We are not required to agree to your request, and we may say "no" if it would affect your care.

If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operation with your health insurer.

We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.

We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months

Get a copy of this privacy notice.

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated.

You can complain if you feel we have violated your rights by contacting us.

We will not retaliate against you for filing a complaint.

B. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

~ Share information with your family, close friends, or others involved in your care.
~ Share information in a disaster relief situation.
~ Include your information in a hospital directory.

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

I**n these cases, we never share your information unless you give us written permission:**
~ Marketing purposes
~ Sale of your information
~ Most sharing of psychotherapy notes

C. We typically use or share your health information in the following ways:

Treating you
We can use your health information and share it with other professionals who are treating you. A doctor treating you for an injury asks another doctor about your overall health condition.

Running our organization
We can use and share your health information to run our practice, improve your care, and contact you when necessary.

We use health information about you to manage your treatment and services.

Bill for our services
We can use and share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situation such as:

~ Preventing disease
~ Helping with product recalls
~ Reporting adverse reactions to medications
~ Reporting suspected abuse, neglect, or domestic violence
~ Preventing or reducing a serious threat to anyone's health or safety

Research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Work with a medical examiner or funeral director.

We can share health information with a coroner, medical examiner, or funeral director at the death of an individual.

WE CAN USE OR SHARE HEALTH INFORMATION ABOUT YOU:

~ For worker's compensation claims
~ For law enforcement purposes or with a law enforcement official
~ With health oversight agencies for activities authorized by law
~ For special government functions such as military, national security, and presidential protective services.

Responding to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

We must follow the duties and privacy practices described in this notice and give you a copy of it.

We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

I acknowledge that I have been served this notice.

_____ Date of Signature___/___/___

Signature of Patient or Patient's Guardian

PATIENT AUTHORIZATION FOR USE/ DISCLOSURE OF PROTECTED HEALTH INFORMATION

I,_____understand **CHISOVEREIGN, PLLC** is authorized by me to use or disclose my protected health information. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of **CHISOVEREIGN, PLLC**, or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

Description of the disclosure being requested (check all that apply):

[ ] SEND COPIES OF ALL PROGRESS NOTES:

[ ] SEND COPIES OF ALL PROGRESS NOTES FOR SPECIFIC DATES OF SERVICE: _____

[ ] SEND COPIES OF LAB RESULTS

[ ] VERBAL COMMUNICATION:

[ ] OTHER _____

This authorization permits **CHISOVEREIGN, PLLC** to send the protected health information ONLY to this address or fax number:

Release / send to [ ]

OR

Obtain from [ ]

Name: _____

Address: _____

_____

Fax: _____

Purpose(s) of the information: [ ] Transfer of Care [ ] Coordinate Care [ ] Other: _____

This authorization shall expire on_____. After this date, CHISOVEREIGN, PLLC can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If left blank, release will expire 2 years from date signed.

I fully understand and accept the terms of this authorization.

Patient/Guardian Signature	Patient Date of Birth	Date

PATIENTS' RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").
Please tell us if you don't understand this authorization, and we will explain it to you.

You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to our office or your insurance company, if applicable.

You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

If this office initiated this authorization, you must receive a copy of the signed authorization.

Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

In order for a medical provider to release "Psychotherapy Notes" to a third party, the patient who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.

CHISOVEREIGN

REFILLS NEEDED ON NON- APPOINTMENT DAYS

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There will be a $25 charge for this service, which is not reimbursed by insurance AND due at the time of the request.

INSTRUCTIONS ON HOW TO OBTAIN A REFILL ON NON-APPOINTMENT DAYS

YOU WILL NEED TO HAVE YOUR PHARMACY FAX US A REFILL REQUEST, our fax number is 703-246-0012 OR by sending an email to admin@chisovereign.com and then leave the following information. After having the pharmacy fax us a request, please call our office (703-246-0011 ext. 13) and leave your name and daytime number, credit card number, with expiration date and 3–digit code on the back of the card and your refill will be processed.

Doctor's Name
Patient's Name and DOB
Medication name and dosage
Date current prescription will run out
Daytime Telephone number (very important if there are any questions)

Delivery Preferences:

[ ] PICK UP prescription at Chisovereign office (Monday to Friday 9:00 a-m -5:00pm) FEE due at time of pick up.

OR

[ ] MAIL prescription: give current address and a credit card information and authorization to process $25 fee.

Credit card information details required for processing are:

1. TYPE OF CREDIT CARD
2. CREDIT CARD NUMBER
3. NAME ON CREDIT CARD
4. EXPIRATION DATE w/ 3-DIGIT CODE ON BACK OF CARD