NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

Patient Information (All Fields are Mandatory) Today's Date _____

Patient's First Name		Middle Name		Last Name (as it appears on insurance card or ID)
Legal Sex	Marital Status (Circle One) Single / Mar / Div / Sep / Wid	Date of Birth (Age)		Social Security Number
Mailing Address	Apt./Suite #	City,	State	Zip
Grade In School	School Attended		School Phone Number	
Best Phone Number Home Cell Work	Secondary Phone Number Home Cell Work		Email Address (for appointment reminders and patient portal only)	
Ethnicity (circle all that apply)	Caucasian or White / Black or African-American / Hispanic / Asian / Native Hawaiian or other Pacific Islander / American Indian or Alaska Native / Other / Decline			
How did you hear about us? Circle one or more of the following: Physician Therapist Relative/Friends Insurance Co. Internet Other	Name of Referring Physician / Therapist		Phone #	
Local Pharmacy Name / Address	Phone / Fax Number			

Guarantor Information (Responsible Party)

First Name	Middle Name	Last Name	
Mailing Address (if different than above)	Apt./Suite #	City, State	Zip
Date of Birth	Social Security Number	Best Phone Number	Relation to Patient

Primary Health Insurance (NPWC will need a copy of all active insurance cards, both sides)

Is This Patient Covered by Medical Insurance? NO ____ YES ____ Medicare ____ Medicaid ____ Other _____

Insurance	Insurance Phone #	Insurance Address	State	Zip
Subscriber's ID #		Group #	CoPay / CoInsurance / Deductible	
Subscriber's Name (as it appears on insurance card or ID)		Relation to Patient (Self, Spouse, Child, Life Partner, Other)		
Subscriber's Social Security Number	Subscriber's Birthdate (mandatory)		Subscriber's Phone # (mandatory)	

Secondary Health Insurance

Insurance	Insurance Phone #	Insurance Address	State	Zip
Subscriber's ID #		Group #	CoPay / CoInsurance / Deductible	
Subscriber's Name (as it appears on insurance card or ID)		Relation to Patient (Self, Spouse, Child, Life Partner, Other)		
Subscriber's Social Security Number	Subscriber's Birthdate (mandatory)		Subscriber's Phone # (mandatory)	

Emergency Contact (In case no one is listed, 911 will be called if necessary)

Person to Notify in Case of Emergency? (Not Living At Same Address)	Relation to Patient	Primary #	Secondary #

NEUROPSYCH
WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

ASSIGNMENT OF BENEFITS

I certify the accuracy of the patient and insurance information provided above and hereby assign to NeuroPsych Wellness Center, PC (NPWC) any insurance (commercial or government) and/or third party benefits available for healthcare services provided to me. I authorize the use of this signature on all my insurance submissions whether electronic or manual. I understand that NPWC has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to NPWC, I agree to forward to NPWC all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. I understand that my healthcare benefits may assign a portion of the bill to me and agree to pay any balance not covered (co-payment, co-insurance, insurance deductible, pre-existing condition, failure to obtain a referral/prior authorization, etc). Any unpaid balances may be turned over to a third party for collections and the patient (or patient's legal guardian) will be responsible for all collection charges (15% of outstanding balance), in addition to, interest (6% of outstanding balance), attorney and/or court costs.

X _____

Parent / Legal Guardian Signature Date

CONSENT FOR DIAGNOSIS AND TREATMENT

Name of Patient: _____ Date of Birth: _____

(Print Patient Name)

Name of Parent or Guardian (if patient is a minor): _____

(Print Name)

I acknowledge that I am voluntarily giving my permission to the authorities of NeuroPsych Wellness Center, PC and the Provider in charge, as they may deem necessary, to provide Mental Health services to the person named above. This will include discussion of tentative diagnosis, methods and modalities to be used in treatment and possible outcomes. I understand that as a part of this process, the person above may be recommended to receive diagnostic testing, psychological testing, psychotherapy and/or medication management. I understand that treatment outcomes cannot be guaranteed, and that treatment can at times be painful and difficult. I understand that I have the ability to decline the aforementioned services at any time, but this may affect the patient's treatment process and outcome.

I understand that the clinic does not provide 24 hours coverage for medical/psychiatric need. In case of an urgent or life threatening situation, I would either call 911 or go to the nearest emergency.

Any patient seeing the Nurse Practitioner, could be discussed with and supervised by Dr. Kumar, Medical Director.

If applicable, I agree to practice contraceptive measures while taking any psychotropic medications as they can be harmful to an unborn baby. I will notify my physician in advance before a planned pregnancy.

I also understand that refusal to comply with the Provider's recommendations could result in grounds for termination of the patient - physician relationship. I also understand that I have the right to terminate the relationship at any time.

I further acknowledge that I have read and understand the Policies and Procedures, and that I understand the limits of confidentiality regarding treatment, and the office policies regarding scheduling, emergency coverage, fees and billing, insurance filing, missed appointments, court appearances, copying records, prescription refills, phone consultations, etc. I acknowledge my understanding of and my willingness to abide by these policies and procedures by my signature below.

X _____

Patient, Parent or Legal Guardian Signature Date

_____

Witness Date

Patient _____

DOB _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

MEDICAL HISTORY/INFORMATION

Briefly state the reason you would like your child to see a Psychiatrist/Therapist:	

Primary Care Physician:	Facility:	Phone Number:
Other Psychiatrist/Therapist:	Facility:	Phone Number:

Is your child presently taking any prescription medications?	❑ YES	❑ NO

If yes, please list them below:

Medication:	Dosage:	How long have you taken it:	Prescribing Doctor:

Height:	Weight:	When was your child's last medical exam?	
Child smokes? ❒ YES ❒ NO	If so, how much?		
Has your child ever had a head injury?	If so, when?	Has your child ever had a seizure?	If so, when?

Does your child have any medication allergies ❑ YES ❒ NO	If so, which?

Has your child previously been treated by a psychiatrist? ❑ YES ❒ NO	If so, when?	Briefly describe the reason:
Has your child previously been treated by a therapist? ❑ YES ❒ NO	If so, when?	Briefly describe the reason:
Has your child ever been hospitalized for psychiatric reasons? ❑ YES ❒ NO	If so, when?	Briefly describe the reason:

FAMILY HISTORY/INFORMATION

Father's Name:	❑ Living	Occupation:		Age:
	❑ Deceased	Cause of Death:		Age at time of Death:
Mother's Name:	❑ Living	Occupation:		Age:
	❑ Deceased	Cause of Death:		Age at time of Death:
Child's parents divorced/separated?	❑ YES	❑ NO	If yes, what age was the child when they separated?	

If the parents are separated, who has primary custoy?

List any siblings and their ages:			
List all current members of your household:			

Patient _____

DOB _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

FAMILY HISTORY/INFORMATION CONTINUED

Please check all that apply:

	FATHER	MOTHER	SIBLINGS	GRANDPARENTS
Alcoholism	❒	❒	❒	❒
Drug Abuse	❒	❒	❒	❒
Depression	❒	❒	❒	❒
Manic Depression	❒	❒	❒	❒
Anxiety	❒	❒	❒	❒
Suicide	❒	❒	❒	❒
ADHD	❒	❒	❒	❒
Obsessive/Compulsive Disorder	❒	❒	❒	❒
Eating Disorder	❒	❒	❒	❒
Other Disorders	❒	❒	❒	❒

Does your child have a history of physical, verbal, or sexual abuse?	❑ YES	❑ NO
If yes, please explain:		
Does your child have a history of legal difficulties?	❑ YES	❑ NO
If yes, please explain:		

DEVELOPMENTAL HISTORY

During pregnancy, was there any bleeding?			❑ YES	❑ NO
During pregnancy, was there a problem with high blood pressure?			❑ YES	❑ NO
Please check any substances that were used during pregnancy:				
❑ Tobacco	❑ Alcohol	❑ Illegal Drugs	❑ Prescription Medications	❑ Other
If any are checked, Please explain:				
Did the Mother suffer any illness during pregnancy?				
Were there any other difficulties during pregnancy?				
Was the pregnancy full term?			❑ YES	❑ NO
If premature, how many weeks?				
Type of delivery:		❒ Normal	❑ Cesarean	❑ Breech
Birth Weight:	Length of Labor:		Condition of child at birth:	
Was oxygen given at birth?			❑ YES	❑ NO
At what age did your child:	Walk alone:	Use single words:	Form sentences:	Toilet train:
Has your child ever had an eye and/or hearing exam?			❑ YES	❑ NO
If yes, what were the results?				
Has your child experienced a head injury?			❑ YES	❑ NO
If yes, please explain:				
Has your child experienced a loss of consciousness?			❑ YES	❑ NO
If yes, please explain:				
Was your child adopted?			❑ YES	❑ NO
If yes, at what age:		Does your child know?	❑ YES	❑ NO
Has your child ever been separated from either parent?			❑ YES	❑ NO
If yes, please explain:				

Patient _____

DOB _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

LEGAL HISTORY			
Has your child been involved with the police or juvenile court system?		❑ YES	❑ NO
If yes, please explain:			

SCHOOL HISTORY			
School Currently Attending:			Grade:
Previous Schools Attended:			Grades:
			Grades:
School Attendance Record:	❑ Excellent	❑ Good	❑ Poor
Has your child experienced any problems academically?		❑ YES	❑ NO
If yes, please explain:			
Has your child repeated any grades?		❑ YES	❑ NO
If yes, please explain:			
Has your child experienced any social problems at school?		❑ YES	❑ NO
If yes, please explain:			
Has your child had detention?		❑ YES	❑ NO
If yes, please explain:			
Has your child had suspension?		❑ YES	❑ NO
If yes, please explain:			
Has your child experienced any traumatic experiences related to school?		❑ YES	❑ NO
If yes, please explain:			
Has your child had psychological testing?		❑ YES	❑ NO
If yes, when:	Where:		
Has your child ever had special education services?		❑ YES	❑ NO
If yes, please explain:			
Is your child currently in special education?		❑ YES	❑ NO
If yes, please explain:			

SUBSTANCE ABUSE HISTORY

Please check all that apply:

SUBSTANCE	History of use?		Age of first use:	Date of last use:	Use within the past year?	
Alcohol	❑ YES	❑ NO			❑ YES	❑ NO
Barbiturates	❑ YES	❑ NO			❑ YES	❑ NO
Xanax, Valium, Librium	❑ YES	❑ NO			❑ YES	❑ NO
Cocaine, Crack	❑ YES	❑ NO			❑ YES	❑ NO
Heroin, Opiates	❑ YES	❑ NO			❑ YES	❑ NO
Marijuana	❑ YES	❑ NO			❑ YES	❑ NO
PCP, LSD, Mescaline	❑ YES	❑ NO			❑ YES	❑ NO
Inhalants	❑ YES	❑ NO			❑ YES	❑ NO
Caffeine	❑ YES	❑ NO			❑ YES	❑ NO
Nicotine	❑ YES	❑ NO			❑ YES	❑ NO
Amphetamines, Speed, Uppers, Crystal Meth	❑ YES	❑ NO			❑ YES	❑ NO
Designer Drugs, Ecstasy	❑ YES	❑ NO			❑ YES	❑ NO

Patient _____

DOB _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

Over-the-counter drugs	❑ YES	❑ NO			❑ YES	❑ NO

If your child currently uses any of the above substances, please describe when and where you typically use:

If your child currently uses any of the above substances, please describe how it has affected your family and friends, including how they perceive her/his use:

If you child currently uses any of the above substances, how does she/he perceive her/his use?

Has your child ever received substance abuse treatment?	❑ YES	❑ NO

Has your child ever had:	❑ Blackouts	❑ DUI	❑ Seizures	❑ Tremors	❑ Legal Charges	❑ Hallucinations

REPORT OF CURRENT AND PAST SYMPTOMS

Please check any problems that your child either has had in the past or is currently having.

Current	Past		Current	Past	
❒	❒	Obsess about checking, counting/or washing hands	❒	❒	Fidgety, restless, overactive
❒	❒	Hear voices	❒	❒	Talking/acting without thinking
❒	❒	Feel people are after you, against you, following you	❒	❒	Short attention span
❒	❒	Unusual thinking	❒	❒	Frequent daydreams
❒	❒	Odd speech/thinking	❒	❒	Self-mutilation
❒	❒	Not interested in making friends	❒	❒	Bored easily
❒	❒	Fear of becoming fat	❒	❒	Vandalism
❒	❒	Engage in self-induced vomiting	❒	❒	Fire-setting
❒	❒	Gorging on food	❒	❒	Nightmares
❒	❒	Excessive dieting/exercise	❒	❒	Afraid to leave a loved one
❒	❒	Use laxatives	❒	❒	Fear of strangers
❒	❒	Eat things that are not food	❒	❒	Often sick on school/work days
❒	❒	Shy	❒	❒	Refusing to talk
❒	❒	Worried about anything / everything	❒	❒	Defiant of authority
❒	❒	Selfish	❒	❒	Often disobedient
❒	❒	Disorganized	❒	❒	Argumentative/sudden anger
❒	❒	Avoid adults	❒	❒	Upset of minor changes
❒	❒	Lack of self-confidence	❒	❒	Stubborn
❒	❒	Friendly	❒	❒	Temper tantrums
❒	❒	Enthusiastic	❒	❒	Lack of guilt over wrong doing
❒	❒	Slow moving	❒	❒	Bullies others
❒	❒	Easily embarrassed	❒	❒	Sexually acting out
❒	❒	Few close friends	❒	❒	Lying
❒	❒	Lack of responsiveness to others	❒	❒	Truancy
❒	❒	Messy	❒	❒	Physically aggressive toward others
❒	❒	Careless, reckless	❒	❒	Theft
❒	❒	Learning difficulties	❒	❒	Problems with long-term memory
❒	❒	Difficulty paying attention	❒	❒	Problems with short-term memory

Patient History Form Completed by _____Date_____

Patient _____

DOB _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

MOOD DISORDER QUESTIONNAIRE

Please answer each question as honestly as possible.

Has there ever been a period of time when you were not your usual self and…		
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	❑ YES	❑ NO
…you were so irritable that you shouted at people or started fights or arguments?	❑ YES	❑ NO
…you felt much more self-confident than usual?	❑ YES	❑ NO
…you got much less sleep than usual and found you didn't really miss it?	❑ YES	❑ NO
…you were much more talkative or spoke faster than usual?	❑ YES	❑ NO
…thoughts raced through your head or you couldn't slow your mind down?	❑ YES	❑ NO
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❑ YES	❑ NO
…you have much more energy than usual?	❑ YES	❑ NO
…you were much more active or did many more things than usual?	❑ YES	❑ NO
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❑ YES	❑ NO
…you were much more interested in sex than usual?	❑ YES	❑ NO
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❑ YES	❑ NO
…spending money got you or your family in trouble?	❑ YES	❑ NO
If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	❑ YES	❑ NO

How much of a problem did any of these cause you – such as being unable to work; having family, money, or legal troubles, getting into arguments or fights?

❑ No Problem	❑ Minor Problem	❑ Moderate Problem	❑ Serious Problem

During the past month, have you often been bothered by feeling down, depressed, or hopeless?	❑ YES	❑ NO
During the past month, have you often been bothered by little interest or pleasure of doing things?	❑ YES	❑ NO

PATIENT HEALTH QUESTIONNAIRE – PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all **0**	Several days **1**	More than half the days **2**	Nearly every day **3**
1. Little interest or pleasure in doing things.	❒	❒	❒	❒
2. Feeling down, depressed or hopeless.	❒	❒	❒	❒
3. Trouble falling/staying asleep, sleep too much.	❒	❒	❒	❒
4. Feeling tired or having little energy.	❒	❒	❒	❒
5. Poor appetite or overeating.	❒	❒	❒	❒
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	❒	❒	❒	❒
7. Trouble concentrating on things, such as reading the newspaper or watching television.	❒	❒	❒	❒
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	❒	❒	❒	❒
9. Thoughts that you would be better off dead or of hurting yourself in some way.	❒	❒	❒	❒
Score	0	_____	_____	_____

A. How difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

❑ Not difficult at all	❑ Somewhat difficult	❑ Very difficult	❑ Extremely difficult

B. In the past **two years** have you felt depressed or sad most days, even if you felt okay sometimes? ❒ Yes ❒ No

Symptoms _____ Severity Score _____

Office Policies

REFERRAL / AUTHORIZATION INFORMATION

Many insurance carriers require you to obtain a referral and/or authorization for mental health services from the primary care doctor or the insurance company. **The responsibility of obtaining a referral is that of the patient or the patient's guardian for your first appointment and thereafter, if required.** Failure to get an 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 the authorization.** You are also required to bring your insurance card and photo ID/driver's license (if under 18, the parent/guardian's ID) at the time of your first appointment. Failure to do so will cause you to be responsible for the entire visit(s) payment and any surcharges.

PRESCRIPTION REFILLS

When you see the doctor, a prescription will generally be written for your routine medication to last until your next follow up.

- It is patient's responsibility to keep up with the follow-up appointment to obtain enough medication on time. To minimize errors and for your safety, we discourage medication refills in between scheduled appointments.
- Please call your pharmacy at least **three (3)** business days before you expect to run out of medication and ask the pharmacy to manually fax us the medication refill request. Our provider may refill medication only enough to cover until the next appointment.
- Our provider may refuse to refill any medication if they believe it is clinically necessary to evaluate the patient before prescribing medication.
- A police report is required if a medication refill is requested for a controlled medication due to being lost or stolen.
- Should you need a prior authorization from insurance completed by our office for your prescription, please allow up to 72 hours for completion.

CANCELLATION POLICY

Appointments scheduled at NEUROPSYCH WELLNESS CENTER, PC are specific time slots allocated exclusively for the benefit of the scheduled patient. We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us in advance if you are unable to do so. Your provider and other patients are directly affected if you fail to show up for your scheduled appointment.

- All appointments with the Psychiatrist, MD and/or the Nurse Practitioner, must be cancelled before **24 business hours** (not including the weekend) prior to the scheduled appointment. Failure to do so will result in an automatic $100.00 missed appointment charge. If you are sick or an emergency/unexpected event has occurred, a medical doctor's note or receipt/excuse note is required to waive the charge within 30 days of the missed appointment.
- All appointments for the Therapist, Licensed Professional Counselor, must be cancelled before **48 business hours** (not including weekend) prior to the scheduled appointment. Failure to do so will result in an automatic $100.00 missed appointment charge. If you are sick or an emergency/unexpected event has occurred, a medical doctor's note or receipt/excuse note is required to waive the charge within 30 days of the missed appointment.
- I understand that, due to high call volume, calls may be routed to an automated voicemail. I understand that the voicemails are logged with the time and date of receipt.
- I understand that it is my responsibility to check the appointment card at the time that it is issued to verify the proper date and time are listed on the card. NEUROPSYCH WELLNESS CENTER, PC **will not waive the missed appointment fee because of an error on a card**. Reminder calls/texts/e-mails are a courtesy and it is the patient's responsibility to remember any appointments scheduled either in person, over the phone or by a third party.
- I understand that my insurance or a third party will not cover the missed appointment charge and it is my responsibility.
- I understand that if I have 2 or more missed appointments with the balance unpaid, future appointments will be cancelled and appointments will not be scheduled until the balance has been cleared. Medication refills may be refused due to being noncompliant with your recommended plan of care with your provider, as discussed at the last visit due to missed appointments.
- I understand that if I am 10 or more minutes late for my appointment, I will be rescheduled and assessed the missed appointment fee.
- In the event of snow or inclement weather, you may cancel an appointment with less than the required notice if **Fairfax County Government (not the school)** is closed and if you call to cancel **PRIOR** to the appointment time.

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

FINANCIAL POLICY

- Not all services we provide are covered by your insurance company. Some insurance companies arbitrarily select certain services that they will not cover. While filing the insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.
- If your insurance coverage or your insurance carrier changes and you do not notify NPWC within thirty (30) days of that change or at the time of the appointment, NPWC reserves the right to NOT issue a refund. I agree to waive any insurance policy rights that require refund of the aforementioned monies. I will be able to resubmit the claim on my own.
- All payments for services are due at the time of check-in unless previous arrangements have been made with our billing staff or your services are covered by a contract with the insurance carriers with whom we are in network with. We accept all major credit cards and cash. It is your responsibility to be aware of your deductibles, coinsurance and/or copay amounts. There is a member number on the back of your insurance card should you need to clarify your insurance plan.
- I understand that if I arrive for an appointment without the proper copay, I will be assessed a $10.00 administrative fee to cover the additional administrative cost to the Practice.
- Checks will be accepted only for established patients of the practice. NEUROPSYCH WELLNESS CENTER, PC has a "One Bad Check" Policy. If at any time, a check bounces, we will no longer be able to accept a check from you. Returned checks will result in a $35.00 fee that will be posted to your account.
- Any balances older than sixty (60) days and failure to pay account balances as promised, may be subject to an external collection agency that may affect your credit. Any additional collection fees, including interest, attorney and other court fees, will be added to the patient's account.
- The patient or patient's legal guardian accepts financial responsibility for all clinical and administrative services provided by NEUROPSYCH WELLNESS CENTER, PC.
- The patient or patient's legal guardian authorizes the release of any medical, mental health or other information necessary to process a claim with the insurance carrier

Other Service Charges:

Disability Application: **$100**
Prescription pick-up w/o appointment: **$30**
Prescription mailed w/o appointment: **$40**
Lost/rewritten prescription: **$30**
Medical records: **$15 + .50/page**
Credit card chargeback: **$50**
Letter Charges: **Determined by Provider**

In accordance with the NeuroPsych Wellness Center, PC, the office policies including cancellation and financial, the patient (or patient's legal guardian) hereby understands and agrees to all of the above. By signing this form, I acknowledge that I have read, fully understand, and will abide by the policies and fees indicated in this NEUROPSYCH WELLNESS CENTER, PC Office / Cancellation / Financial Policy Agreement.

Patient / Parent / Guardian's Name: _____

Signature: _____ Date: _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

Patient Record of Disclosures

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their Protected Health Information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

Patient Name: _____ **Date of Birth:** _____

I wish to be contacted in the following manner (check all that apply):

- ☐ Home Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Cell Phone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone: _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication: _____
  - ☐ OK to mail information to address on file
- ☐ Other: _____

Personal Representative of Patient:
I hereby give permission to the person(s) listed below to authorize treatment, attend office visits, and to receive information about the care of the above named patient. This includes but is not limited to: information about the patient's general medical condition and diagnosis (including treatment and payment options), access to medical records (PHI), prescription pick-up, and the ability to set appointments.

- ☐ Name: _____ Relationship: _____ Phone #: _____
- ☐ Name: _____ Relationship: _____ Phone #: _____
- ☐ Name: _____ Relationship: _____ Phone #: _____
- ☐ Name: _____ Relationship: _____ Phone #: _____

Authorization to Receive Reminder Calls, Texts and/or Emails:
NPWC provides reminder calls, texts and/or emails from an automated system as a courtesy to all patients 48 business hours previous to the scheduled appointment. In keeping with the provision of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), NPWC must retain your permission before providing this courtesy service.
By accepting this service and signing below, you are giving NeuroPsych Wellness Center, PC permission to give you a reminder call, text, and/or email, including permission to leave a message on your answering machine/voice mail, or with anyone who might answer your telephone. If you do not wish to receive this courtesy service, please select the "decline" option below.

- ☐ **ACCEPT:** "I would like to receive reminder calls, texts and/or emails and give permission to NeuroPsych Wellness Center, PC to leave a message for me if I am unavailable."
- ☐ **DECLINE:** "I would **NOT** like to receive reminder calls, texts and/or emails and do **NOT** give permission to NeuroPsych Wellness Center, PC to leave a message for me if I am unavailable."

Patient / Parent / Guardian's Name: _____

Signature: _____ Date: _____

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

CONFIDENTIAL EXCHANGE OF HEALTHCARE INFORMATION FORM

PATIENT NAME: _____ **DOB:** _____

Practitioner Section:

A. Treating Behavioral Health Practitioner/ Provider Information:

Name:	**NeuroPsych Wellness Center, PC**	Phone:	**703-865-8686**
Address:	3930 Pender Drive, Suite 350		
	Fairfax, VA 22030		

B. Patient Clinical Information:

1. The patient is being treated for the following behavioral health problem (s):

- ☐ ADHD/ Behavior D/O
- ☐ Adjustment D/O
- ☐ Anxiety D/O
- ☐ Bipolar D/O
- ☐ Depressive D/O
- ☐ Eating D/O
- ☐ Personality Disorder
- ☐ Psychotic D/O
- ☐ Substance Abuse
- ☐ OTHER: _____

2. The patient is taking the following prescribed psychotropic medication(s)?

- ☐ Anticonvulsant/Mood Stabilizer
- ☐ Antidepressant - MAOI
- ☐ Antidepressant - SSRI
- ☐ Antidepressant - Tricyclic
- ☐ Antidepressant - Wellbutrin
- ☐ Antipsychotic - Atypical
- ☐ Antipsychotic - Typical
- ☐ Anxiolytic
- ☐ Clozaril
- ☐ Lithium
- ☐ Stimulant
- ☐ Other _____

3. Estimated duration of treatment: ☐ < 3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. Coordination of care issues / Other significant information impacting medical or behavioral health care:

_____

_____

Patient Section:

C. PCP/ Medical Practitioner or Other Behavioral Health Practitioner/ Provider Information:

Name:	Phone:
Address:	
Fax:	

☐ I hereby voluntarily, freely and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner / provider listed in Section B above. The reason for this release of information is to assist in the continuity and coordination of my treatment. This consent will automatically last **one year** from the date signed. I understand that I may reverse my consent at any time.

_____

Patient Signature / Date

I do not wish to have my information shared with:

- ☐ My PCP/ medical practitioner
- ☐ My other behavioral health practitioner(s)/ provider(s)

I am not currently receiving services from:

- ☐ PCP/ medical practitioner
- ☐ Any other behavioral health practitioner/ provider

DATE FORM MAILED OR FAXED TO OTHER PRACTITIONER / PROVIDER: _____

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal law regulations (42) CFR Part 2 prohibit you from making any further disclosure of it without written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of the medical or other information is not sufficient for this purpose.

PLEASE PLACE A COPY OF THIS FORM IN THE PATIENT'S MEDICAL RECORD

NEUROPSYCH WELLNESS CENTER, PC

OFFICE USE ONLY:

MRN _____

Updated _____

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.

NeuroPsych Wellness Center, PC (NPWC) is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, and applicable state law, to protect the privacy of your protected health information. This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It contains information about our legal duties and your rights concerning your medical information.

How May We Use or Disclosure Your Medical Information?

NPWC physicians, clinicians and staff may use and share your information for the following purposes: (i) providing you the best medical treatment and care, (ii) billing you, your insurance company or any third party for medical services, (iii) operating our medical facility, including for business management and administration purposes, (iii) sharing information with other healthcare providers and other medical facilities as necessary, (iv) responding to requests for your information from law enforcement and other government, including court orders and subpoenas, (v) complying with state and federal law, and (vi) for help with public health and safety issues, including emergencies and disaster relief efforts.

What are Our Responsibilities with Respect to your Medical Information?

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 you are entitled to a copy. We will not use or share your information other than as described here unless you authorize us in writing to do so. You may change your mind at any time. If you do, let us know in writing.

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

What are Your Rights with respect to your Medical Records or Information?

You have the right to request that we change your personal information as well as your privacy information. Contact the Privacy Officer for information about how to do this. You may request confidential communication to discuss your medical records and you may ask us to limit the information we share with third parties. You are also entitled to get a list (accounting) of all parties with whom we have shared your information with over the past six years. We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

You may also choose a third party to act on your behalf, including the release of your health information. If needed, we can also provide you a copy of this privacy notice.

NPWC is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. NPWC is required to abide by the terms of the Notice currently in effect. NPWC reserves the right to 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.

How can you file a complaint if you feel your rights have been violated?

Individuals may complain to NPWC's Privacy Officer and to the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights, without fear of retaliation by the organization, if they believe their privacy rights have been violated.

The privacy and confidentiality of patient medical information and records is of the utmost importance to NeuroPsych Wellness Center, PC. We take great pride in maintaining the same.

I acknowledge that I have been provided information regarding NPWC's Privacy Provisions.

X

Patient, Parent or Legal Guardian Signature | Patient/Guardian Name | Date