Registration Form

Welcome to our office. Please complete all 4 pages of this registration form.

Client Info (person appointment is for)

_____
First, Mid initial, Last (Mr., Mrs., Ms., Dr.)

_____
Street Address

_____
City, State Zip Code

_____
Home phone (may we leave a message?____)

_____
Work phone (may we leave a message?____)

_____
Cell phone (may we leave a message?____)

_____
Email (may we send you an email?____)

_____
Date of Birth & Social Security Number

_____
Employer Name

_____
Referring Therapist's Name & Phone#

_____
Major Illness(es) & Date of Last Physical

_____
Primary Care Physician Name & Phone #

_____
Medication Allergies (If none check here_____)

_____
Medication(s) currently used

_____

_____

Gender_____Marital Status_____

Employed?_____

Full Time Student?__Half Time Student?__
Is Illness: Employment $\frac{1}{2\pi}$, Auto Accident $\frac{1}{2\pi}$,
or Other Accident $\frac{1}{2\pi}$ Related?

Person Responsible for Paying the Account

_____
Name (If same as client check here_____)

_____
Street Address (If same as client check here____)

_____
City, State Zip Code (Leave blank if same)

_____
Phone

Insurance - if you want us to file claims for you, please have your card out for photocopying. We are in-network for <u>BCBS PPO</u> only.

Client Relationship to Primary Insured (circle one):
Self, Spouse, Child, Other

_____
Non-Client Insured's Name (same as client ____)

_____
Non-Client Insured's DATE OF BIRTH & ssn
(needed for claims)

_____
Phone (If same as client check here____)

_____
Address (If same as client check here_____)

_____
City, State Zip (If same as client check here____)

_____
ID Number of Policy & Group Number

_____
Insurance Co. Name

_____

Non-Client Insured's Employer (same as client ____)

- **Please complete all 4 pages**
- **Please have your insurance card out for photocopying if you want us to file claims for you.**

INSURANCE:

We accept and file most major medical insurance plans, however we are not in network with all plans. If you want our office manager to file insurance claims, please provide a copy of your insurance card as well as any updates/changes. If we file, your insurance the company may pay us directly. You are responsible to contact your insurance company for information about your out-patient mental health benefits. Benefits vary widely even within the same insurance plan. If your plan does not pay us within a 32 days, you will be billed. All claims filed with insurance companies are subject to benefit and eligibility limitations at the time the claims is filed. Out of network services will be charged at our current fee schedule.

NON-COVERED SERVICES: Any care not paid for by your existing insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. This may include fees for prior authorizations, prescription refills, telephone consultations and letters writing.

PLEASE CALL YOUR INSURANCE TO OBTAIN:

1. **REFERRALS AND AUTHORIZATIONS:** You are responsible for obtaining any authorization or pre-certification required by your insurance company for your initial visit with our company. Failure to obtain authorization for services may result in increased cost to your for services provided. Please check with your insurance carrier to find out what if any authorization is needed.

2. **The name and address of your *mental health* insurance company** - ***This may NOT be the same company*** that is on your insurance card for your other medical claims. For your own financial planning, you will want to specifically verify whether Bob or Susan Sholtes are in network with your mental health insurance company.

Payment Method

We accept cash, checks, credit cards, and FSA.

If you decide to pay with a credit card please speak with the Office Manager.

All past due payments over 90 days will be charged 1.5% per month of any balance due.

Signature below indicates understanding and agreement with policies stated above. A separate release of information will be needed before contacting your doctor.

_____	_____
Signature of Client Date	**Signature of Responsible Party Date**
_____	_____
Signature of Insured (if different) Date	**Signature of Parent (if client is minor) Date**

Policies:

1. **MEDICAL RECORDS:** The confidentiality of your medical record is our number one priority at S&A. All medical record requests must be submitted in writing on our medical record release form.

2. **TELEPHONE CONSULTATION, FORMS, AND LETTERS:** Telephone consultations will be charged based on the time spent on each call. Please be aware that there may be an additional charge for after hour calls, except for life-threatening emergencies. Thank you for understanding that our providers first priority each day must be to see the patients in the office, therefore, they will complete forms letters, and prior authorizations as time permits. Most will be completed within 7—10 business days.

   Fees for telephone consultation, forms and letters There is a **minimum fee of $20.00**

   - 15 minutes: $75.00
   - 30 minutes: $150.00
   - 60 minutes: $225.00

3. **PRESCRIPTION REFILLS:** Please see **PRESCRIPTION DRUG POLICY AND PROCEDURES** on page 5 (this is only for persons seeing Dr. Bob Sholtes)

4. **APPOINTMENTS:** Appointments are held especially for you and they are a valuable resource at our practice. If you are unable to keep your scheduled appointment, please provide a minimum of 1 working day advance notice Our work week is Tuesday through Saturday. We charge ***for missed appointments or less than one working day cancellation of appointments*****.** Fees for missed appointments are due at or prior to your next appointment. ***Appointment reminder calls or emails are attempted as a courtesy for you, but it is your responsibility to keep track of appointment dates and times.***

5. Emergency coverage is not provided by our practice. We provide outpatient, non emergency services. ***You are instructed to utilize emergency services available in the community for all life threatening emergencies.*** We will attempt to be available if you are experiencing any urgent need for treatment during our working week (Monday-Saturday), but we may not be able to respond during a busy work day until the end of that day or the next work day. We are not available after hours. Any messages left after hours may not be heard until the next scheduled work day. If you do not receive a timely response to any messages left on our voice mail, please call again, in case we did not get the first message.

Signature below indicates understanding and agreement with policies stated above.
A separate release of information will be needed before contacting your doctor.

_____ _____

Signature of Client Date **Signature of Responsible Party Date**

_____ _____

Signature of Insured (if different) Date **Signature of Parent (if client is minor) Date**

PLEASE ALSO READ AND SIGN THE CLIENT AGREEMENTS AND AUTHORIZATIONS ON PAGE 4.
A copy of our privacy policies (3 pages) is available on a second clipboard for you to read or to take with you.

CLIENT AGREEMENTS AND AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby consent to the treatment provided by Sholtes and Associates, its employees or designees. I authorize the mental and physical health care services deemed necessary or advisable by my caregivers to address my needs.

AUTHORIZATION FOR RELEASE OF PERSONAL HEALTH INFORMATION

I authorize use and disclosure of my personal health information for the purposes of diagnosing or providing treatment for me, obtaining payment for my care, or for the purposes of conducting the healthcare operations of Sholtes and Associates. I authorize Sholtes and Associates to release any information required in the process of applications for financial coverage for the services rendered. This authorization provides that Sholtes and Associates may release objective clinical information related to my diagnosis and treatment, which may be requested by my insurance company or its designated agent.

ASSIGNMENT OF INSURANCE BENEFITS/ PAYMENT GUARANTEE/ COLLECTION FEE

I authorize payment to be made directly to Sholtes and Associates for insurance benefits payable to me.
I understand that I am financially responsible to Sholtes and Associates for any covered or non-covered services, as defined by my insurer. I understand that if my account balance becomes overdue and the overdue account is referred to a collection agency, I will be responsible for the costs of collection including reasonable attorney's fees.

PRIVACY POLICY I acknowledge having received Sholtes and Associates, "Notice of Privacy Policies and Practices." My rights, including the right to see a copy of my record, to limit disclosure of my health information, and to request an amendment to my record, are explained in the Policy. I understand that I may revoke in writing my consent for release of my health care information, except to the extent Sholtes and Associates has already made disclosures with my prior consent.

FOLLOW-UP SERVICES I agree (_____) or do not agree (_____) to be contacted for follow up services by phone, mail, or e-mail after services at Sholtes and Associates. Failure to agree prevents us from leaving reminders about appointments on your voice mail.

_____ _____

Client Signature (ages 18+) **Date**

If the client is unable to sign, verbal consent given _____.
Reason for inability to sign: _____

FOR MINORS ONLY: I (we) represent that we are the parent(s) or legal guardian(s) of the above named person, a minor. I (we) authorize and consent that our son/daughter receive treatment at Sholtes and Associates for his/her emotional difficulties. I (we) understand that persons employed by the agency other than the therapist may of necessity have access to these records.

_____ _____ _____

_____ _____ _____

Parent/Guardian Signature(s) **Relationship(s)** **Date**

_____ _____

Minor's Signature (ages 12 - 17) **Date**

PRESCRIPTION DRUG POLICY AND PROCEDURES

We want to make you aware of the policies and procedures followed by our office in regards to the medication(s) being prescribed to you.

Our goal is to provide the best psychiatric care and medication management to our patients as possible. Dr. Sholtes is a medical doctor who specializes in the treatment of psychiatric disorders. If he prescribes a medication, he will carefully monitor this with you. The following policies and procedures are in place for your health and safety.

GENERAL PRESCRIPTION INFORMATION

- Please use your medication management appointment to discuss your medication.
- If you have questions about your medications or if you need to report side-effects, you should call the doctors line during regular administrative office hours.
- If you need your medication adjusted or would like to be started on a new medication, we request that you schedule an appointment with enough time to discuss your experiences and the risks/benefits of any change.
- We expect that you keep scheduled appointments as directed, generally every 2-3 months, to keep current as a patient. Your eligibility for prescription refills is determined by keeping scheduled appointments.
- If a controlled substance/narcotic prescription is prescribed to you, it is understood that we are the only doctor providing this medication to you. If you obtain this medication (or similar medication) from another physician, without our knowledge, we will no longer provide prescriptions for this medication, and we may be forced to terminate the doctor patient relationship.

PRESCRIPTION REFILLS

- All prescription refill requests should be handled during scheduled office appointments or by calling the Prescription Refill Line. ***Refills will normally be handled within 3-5 business days*** (not including Holidays or Weekends). Please keep up with your supply of medication to avoid running out.
- Our office does not provide refills for medications after hours or on weekends. For your convenience, you may leave a message on this line 24 hours a day, but requests are handled during administrative office hours only.
- Prescriptions refills for ADD/ADHD, must be written monthly by the doctor, and must be picked up at the office by the patient or an authorized representative.
- Our office does not refill medications for lost or stolen controlled substance prescriptions. If your prescription or medication is lost or stolen and you have difficulty with withdrawal symptoms, you should go to the nearest emergency room.
- Our office does not provide early refills for medications. Any medication dosage changes must be approved by your doctor.

PRESCRIPTION FEES

- ADD/ADHD medications written between appointments $25.00.
- Prescription Refills due to missed or cancelled appointments $25.00/occurrence.
- Prior Authorization for prescriptions (if required by patient's insurance) $25.00/medication

You will be charged the prescription fees and they will not be billed to or reimbursed by your insurance carrier