Holistic Approach Mental Health

Office Policy Information

Ilya Rozenberg, M.S., C.R.N.P.
Kristin Bussell, M.S., C.R.N.P.

Dear Patient,

Welcome to Holistic Approach Mental Health. We are committed to providing you with the best medical knowledge available. In order to accomplish this goal, there are mutual responsibilities and limitation which need to be understood. To ensure we can work together as effectively as possible, please review our policies below.

Office Hours:

Monday: 7 AM - 7 PM

Tuesday: 12 PM - 7 PM

Wednesday: 7 AM - 7 PM

Saturday: 9 AM – 1 PM

Address:

7452 Baltimore-Annapolis Blvd., Suite 102

Glen Burnie, MD 21061

(410) 766-1544

As a patient in this practice, you are expected to:

1. **Pay you co-pay at every visit. It is your responsibility to pay any outstanding balances that is not covered by insurance.**
2. Present your current insurance for verification at every visit.
3. Present your driver's license or any other picture identification if you are paying with a check or are a new patient.
4. Make sure we have your current information on file. At every visit, you will receive a patient information sheet to ensure we have the correct address, telephone number, and insurance. You must sign this form (or give corrections and sign a revised form) indicating all the information we have on file is correct. This form also includes a statement acknowledging that you are the person ultimately responsible for paying your bill.
5. Inform us of changes to your insurance information. You must call us with insurance changes before coming to your next appointment (if require by your insurance) to update the information. If time permits, we will try to get the verification on the day of your appointment; however, if we are unable to, you will be required to pay for your visit in full ($185 for initial visit, $75 for a follow-up) or you may reschedule your appointment to allow time to complete the verification. Insurance verification cannot be completed before 9 AM or after 5 PM.
6. Notify us if you cannot keep your appointment. If you are unable to keep your scheduled appointment, you must notify the office as soon as possible, at least 24 hours in advance.

If we are not notified at least 24 hours before the appointment, you will be subjected to a $25 cancellation fee, which you must pay before you may schedule your next appointment. If you miss your initial appointment, commercial insurance patients will be subjected to a $25 missed appointment fee. Repeat cancellations or “no-shows” jeopardizes your ability to treat you effectively and may result in dismissal from the practice.

7. Request prescription refills before 5 PM Monday--Thursday. Refill requests received after 5PM on weekdays will be processed the next business day. No refills are processed on holidays or weekends. It is your responsibility to make sure that you do not run out of medication before your next appointment. Patients must keep their appointments in order to continue receiving refills on medication. If you have not had a recent appointment, you will be given a refill of only enough medication to last you until the next available appointment (this does not mean the next appointment that is convenient for you).
8. Payment can be made by check, cash, or credit card. Your credit card is required to be in file for us to charge any cancellation fees, no-show fees, etc. that occur throughout your experience with Holistic.

Payment

Full payment of your co-pay and any unpaid balances are your responsibility and will be expected at the time of service. You may pay by cash, credit card, or debit card. A Maryland's Driver's License is required if paying by personal check. Further, please take note of our financial agreement located on the Patient Information Sheet as it clearly outlines the terms and conditions for payment. Ultimately, you are responsible for paying your bill.

We do not accept checks.

Billing

Billing is not completed within our office. It is handled by Avid Medical Billing Services LLC. Any billing questions should be directed to (410) 284-6052.

Medication

Prescribed medication is an important part of your visits and it is essential that you take these medications on a daily-basis or as directed.

In order to provide you with the best medical care and keep problems to a minimum, please ensure you have an adequate supply of medication between visits.

Recommendations:

1. Check the number of pills you have before each visit so that you know whether you will have enough until the next planned visit.
2. Write down the name of your medication(s) and the number of the remaining pills and bring it with you.
3. The provider will then prescribe the number of pills required you to carry you through the next visit.
4. If an appointment is missed, you may obtain a prescription to cover medical requirement only until the next scheduled appointment, (this does not mean the next appointment that is convenient for you), by doing the following:
    a. Reschedule your appointment.
    b. Leave a message for our staff with the name of the medicine(s), dosage, and directions taken per day so that the refill can be written, phoned in, or sent electronically to your pharmacy.
    c. If time permits, the provider will write the necessary prescription(s) on the same day to carry you to the next appointment.
    d. Pick up the prescription(s) the next working day no later than 4:30 PM unless we are able to telephone your pharmacy.

Practitioner Coverage

Our office offers quality psychiatric care provided by licensed board certified Psychiatric Nurse Practitioners. A Psychiatric Nurse Practitioner is an independent health care provider with training and expertise in mental health. Psychiatric Nurse Practitioners in the state of Maryland are licensed by the Board of Nursing as Certified Registered Nurse Practitioners – C.R.N.P. They hold a Master Degree in Nursing and National Board Certification. In the state of Maryland, a Nurse Practitioner may practice independently and in collaboration with physicians in conduction psychiatric evaluations, establishing psychiatric diagnoses, prescribing and managing psychotropic medications, and ordering and interpreting laboratory tests. Nurse Practitioners also educate and counsel individuals, families, and groups.

Ilya Rozenberg, M.S., C.R.N.P. is a licensed Adult Psychiatric Nurse Practitioner. He holds a Master of Science degree in Nursing from the University of Maryland and is board certified by the American Nurses Credentialing Center as an Adult Nurse Practitioner and Clinical Specialist in Adult Specialist in Adult Psychiatric and Substance Abuse. He has provided care to patients and their families across the continuum, including both inpatient and outpatient settings.

Kristin Bussell, M.S., C.R.N.P is a licensed Family Psychiatric Nurse Practitioner. She holds a Master of Science degree from the University of Maryland. She is board certified by the American Nurses Credentialing Center as a Family Psychiatric Nurse Practitioner and Clinical Specialist in both Child/Adolescent and Adult Psychiatry. She has 20+ years in the field of child/adolescent psychiatry and has worked in a variety of settings and levels of care across the pediatric mental health continuum. She takes a family centered, developmental approach to care for children and their families.

Qubenic Yancey, LCPC, is a Licensed Clinical Professional Counselor. She holds a Masters of Arts in Counseling and a Bachelors of Science in Business Administration with a specialization in Healthcare. She provides therapy for adults with severe mental illnesses such as Bipolar Disorder, Schizophrenia, and Major Depression. She has worked in the Healthcare industry for 12 years, and has experience in Healthcare Administration, Crisis Counseling, and Trauma Counseling. She has been a hospital advocate for survivors of sexual abuse and crisis counseling for the mentally ill.

Holistic Approach Mental Health

Receipt of Policies

I, hereby, acknowledge that I have received a copy of the practice policies and agree to abide to them.

_____	_____
Print Patient Name	*Patient Signature* *Date*
_____	_____
Print Parent/ Guardian Name	*Parent/Guardian Signature* *Date*

Holistic Approach Mental Health LLC

Patient Consent Form

Please read and sign the following statements.

1) Consent for treatment

I, _____ (please print name) am voluntarily seeking medical treatment from Holistic Approach Mental Health LLC, a facility dedicated to improving the overall mental health of patients. I am giving permission to the medical and mental health staff to examine me, make diagnoses, and provide treatment in accordance with the information, explanations, and recommendations they provide me.

_____ _____/_____/_____

Patient Signature Date

_____ _____

Translator's Name, if applicable Translator's Signature, if applicable

2) Consent to Bill

- If I do not have medical insurance, I understand that I am responsible for all charges incurred and that I plan to pay for medical treatment at the time of visit.
- If my insurance is accepted, I authorize payment of benefits to Holistic Approach Mental Health or will reimburse Holistic Approach Mental Health if I am paid directly by my carrier.
- I hereby authorize that Holistic Approach Mental Health may furnish information concerning my illness and treatment to my insurance carrier(s) if necessary.
- I am advised that any tests (blood work and other specimens) sent to an outside laboratory will result in additional charges that will be billed to my insurance carrier and/or will be billed directly to me by the laboratory.
- I understand that my insurance may not cover all charges deemed medically necessary.
- I also understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

_____ _____/_____/_____

Patient Signature Date

_____ _____

Translator's Name, if applicable Translator's Signature, if applicable

Holistic Approach Mental Health

Record Release Form

By signing this form, I authorize you to release confidential health information about the patient, by releasing a copy of their medical records, or a summary, or narrative of their protected health information to the physician/person/faculty/entity listed below. This authorization request is voluntary. Treatment, enrollment, or eligibility for benefits may not be conditioned on signing this authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

Patient name: _____ Date of Birth: ____/____/____

I hereby authorize the doctor and staff of Holistic Approach Mental Health to release records concerning my mental health and wellbeing. I understand that the specific type of information disclosed may include a detailed report of examinations, treatments, and other records that pertain to my mental health. Unless otherwise noted, this authorization will expire in 12 months.

The information you may release subject to this release form is as follows:

- ☐ Complete Records
- ☐ Care Plan/Discharge Summary
- ☐ Pathology Reports
- ☐ History & Physical
- ☐ Lab Reports
- ☐ Treatment Records
- ☐ Medication Records
- ☐ Progress Notes

Limitations upon disclosure (if any): _____

The information you may release subject to this signed release form may be sent to:

- ☐ Hospital Phone #: _____ Fax #: _____
- ☐ Primary Care Physician Phone #: _____ Fax #: _____
- ☐ Family Member Phone #: _____
- ☐ Psychiatric Doctor or Therapist Phone #: _____ Fax #: _____

Are we allowed to contact your spouse if necessary? Yes No

Fill out the following contact information:

Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Patient (or representative) Signature: _____ Date: _____

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7452 Baltimore-Annapolis Blvd, Suite 102
Glen Burnie, MD 21061
Phone (410) 766-1544 Fax (410) 766-1551

Patient Information

Name: _____
Date of Birth: _____ Gender: _____
Race: _____ Social Security #: _____
Address: _____Suite/Apartment #: _____
City: _____ State: _____Zip code: _____
Phone: Home: _____ Cell: _____ Work: _____

Complete the following if the patient is a minor:
Mother: _____ Father: _____
Phone: _____ Phone: _____
Legal Guardian: _____ Relationship: _____
Phone: _____
Who does the child live with? _____

Insurance Information

Primary Insurance: _____
Policy #: _____ Group #: _____
Policy Holder Name: _____ DOB: _____
Employer: _____ Relationship to patient: _____
Secondary Insurance: _____
Policy #: _____ Group #: _____
Policy Holder Name: _____ DOB: _____
Employer: _____ Relationship to patient: _____

Parent's authorization
I authorize Holistic Approach Mental Health LLC to apply for benefits on my behalf for services rendered by Holistic Approach Mental Health LLC. I request payment from my insurance company be made directly to Holistic Mental Health LLC. I certify that the information I have reported regarding my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by us at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided when a statement is rendered.

Signature of Subscriber or Beneficiary: _____ Date: _____

All Medical Assistance Patients must fill this form out:

(Prior MHP Patients, now MAPS)

Date: _____

Patient Background

Name: _____ _____ DOB: _____

Race:

- ☐ White
- ☐ Black or African American
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Native Hawaiian or Another Pacific Islander
- ☐ Not Available

Ethnicity:

Are you Hispanic/Latin origin: _____

Primary Language: _____ How well do you speak English: _____
Do you speak another language at home (specify which language)? _____
Marital Status: _____ Employment Status: _____
Highest Level of School/Grade Completed: _____
Are you a veteran? Yes No
Which war are you a veteran of? _____ Time frame enlisted: _____
Would the consumer like to be contacted by the Office of Maryland's Commitment to Veteran's for a purpose of Veteran benefits? Yes No
Number of arrests within the past 30 days: _____

Living Situation

Select one of the following:

- ☐ Private Residence
- ☐ Foster Home Residential
- ☐ Care Crisis Residential
- ☐ Children's Residential Treatment Center
- ☐ Institutional Setting
- ☐ Jail/Correctional Facility
- ☐ Homeless Shelter
- ☐ Other: _____

Consumer Living Situation: (Under 18)

Select one of the following:

- ☐ Both parents
- ☐ One parent, one stepparent
- ☐ One parent
- ☐ Stepparent only
- ☐ Relative Foster Care
- ☐ Residential Setting
- ☐ Juvenile Service

Does this person have legal custody?
Yes No

Does any other person have legal guardianship? Yes No

Legal Custodian Demographic Information

Name: _____ Agency: _____

Address: _____ Phone #: _____

Medical Background

Primary Care Physician: _____ Phone Number: _____

Have they participated in a Self-Help Group in the Last 30 days? Yes No

Are you pregnant? Yes No

Disability Status

Is the consumer deaf of do they have serious difficulty hearing? Yes No

Is the consumer blind or do they have serious difficulty seeing, even with glasses? Yes No

Does the consumer have difficulty dressing or bathing? Yes No

Because of a physical, mental, or emotional condition, does the consumer have serious difficulty doing errands alone such as visiting a doctor's office or shopping? Yes No

Holistic Approach Mental Health

Patient Detail Sheet

(Avid Billing)

Last Name: _____ First Name: _____ MI: ___
Sex: _____ DOB: _____ Marital Status: _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
SSN: _____
Address: _____
City: _____ State: _____ Zip code: _____
Race: _____ Ethnicity: _____ Language: _____
Primary Care Physician: _____ Phone Number: _____
Emergency Contact: _____ Phone Number: _____

Primary Insurance
Name: _____
Policy Number: _____
Group Number: _____
Insurance Phone #: _____
(Number on the back of the card)
Insured Name: _____
SSN: _____
Relationship: _____ DOB: ____
Employer: _____

Secondary Insurance
Name: _____
Policy Number: _____
Group Number: _____
Insurance Phone #: _____
(Number on the back of the card)
Insured Name: _____
SSN: _____
Relationship: _____ DOB: ____
Employer: _____

Guarantor Information (if child-responsible party)
Guarantor: _____
Address: _____
City: _____ State: _____ Zip Code: _____

For Office Use Only:

Provider: _____

Date of Appointment: _____