Beckman Center

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Greenwood, SC 29646

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Our goal with this handout is to provide you with information that we will need, a brief description of why and what you can expect at your next appointment.

You will receive orientation on how we bill for our services and sign various forms that are required in order for you to receive our services.

You will need to **bring with you** at your next appointment the following items:

1. **Proof of Household Income**
2. **Social Security Card**
3. **Medicare, Medicaid, and/or Insurance cards.**
4. **Picture ID (Example: driver's license, school id, wallet photo)**

You will be asked to sign the following consent forms:

1. Financial Information
2. Permission to Follow-up
3. Orientation
4. Voter Registration
5. HIPPA Consent
6. Consent to Examine and Treat
7. Family Member Designation
8. Prescription Pick Up

HOUSEHOLD INCOME:

Acceptable proof of income or ability to pay includes the following:

1. Current paycheck stub(s)
2. Annual tax W-2 form
3. Prior year income tax return
4. Public assistance eligibility documentation (food stamps)
5. Alimony/Child support documentation
6. Letter of award of retirement income, social security, unemployment compensation, insurance annuity, etc.
7. A signed statement that the patient is the beneficiary of a trust or other source of readily available income or payment for health care expenses

A combination of the above would often be required.

PERMISSION TO FOLLOW UP

This form includes your contact information. This form will be sent to our administration office in order for them to contact you to participate in a short telephone survey. This survey will provide valuable information on the services we provide, the treatment you received and your experience with our staff.

ORIENTATION

You will be given a booklet entitled “Spotlight”. It contains our mission statement, your rights as a patient, what you can expect from us, and how we bill. It also contains contact information on all of our locations.

VOTER REGISTRATION

If you are currently not registered to vote, or if you have a family member who would like to register to vote, we can provide you with the necessary forms to achieve this privilege. Your therapist can assist you in completing the form if you need assistance.

HIPAA

You will receive a pamphlet that explains your rights concerning the information we collect from you and maintain in your record. You receive this same documentation at any medical or dental office.

CONSENT TO EXAMINE AND TREAT

This consent form allows a therapist to talk with you, the nurse to monitor or administer medications you receive from a clinic or school. Weight and vitals are obtained at the clinic, and allows the doctor to examine your progress and stability.

FAMILY MEMBER DESIGNATION

You will be given an opportunity to designate a family member or another individual with whom we may discuss your condition with.

PRESCRIPTION PICK UP

The physician may leave sample medications or prescriptions for the medications we prescribe for you to pick up from the clinic. You will have the option to designate someone to pick these items up for you in the event you are not able to obtain them yourself.

We hope that this information has been helpful to you and we look forward to seeing you again.

CMHC BILLING REFERENCE LIST - July 1, 2016

CIS SERVICE CODE	SERVICE DESCRIPTION AND ABBREVIATION	FREQUENCY/TIME SPAN	SERVICE CHARGE
H001-0	Crisis Intervention Service (CI)	20 / 15mins Units day	$42.00
H001-T	Crisis Intervention Service via Telephone(CI)Non Physician	2 / 15 min units day	$42.00
H002	MH Assessment by Non Physician (ASSMT)	8 / 30min units day	$80.00
H003	Individual Therapy (IND TX)	1 / Encounter	$79 $158 $237
H004-001	Family Therapy, patient present (FM TX)	1 / Encounter	$241.00
H004-002	Family Therapy, patient not present (FM TX)	1 / Encounter	$238.00
H005-GTX	Group Therapy (GP TX)	1 / Encounter	$83.00
H005-MFG	Multi Family Group (GP TX)	2 / Encounter	$63.00
H010	Injectable Medication Administration (MED ADM)	See Table	See Table
H012	Psychiatric Diagnostic Evaluation with Medical (PDE) 1st PDE by MD	1 / Encounter day then 1 / Encounter 6 mos	$402 (OO) $694(HA) $653(GT)
H013	Psychiatric Diagnostic Evaluation with Medical -Advanced Practice Registered Nurse (PDE-APRN) 1st PDE by APRN	1 / Encounter day then 1 / Encounter 6 mos	$326.00
H014	Behavioral Health Screening Alcohol/Drug (BHS)	2 / 15 units day	$40.00
H016	Injection Administration (INJ ADM)	40 / 15 units month	$25.00
H017	MH Service Plan Development by Non Physician (SPD)	12 / 15 min units day	$41.00
H017-T	MH Service Plan Development by Non Physician via Telephone (SPD)		
H021-O	Nursing Services (NS)	7 / 15 min units day	$43.00
H021-M	Nursing Services Medication Monitoring (NS)	7 / 15 min units day	
H021-T	Nursing Services via telephone (NS)	7 / 15 min units day	
H031	Targeted Case Management - In Field (TCM)	16 / 15 min units day	$36.00
H032	Targeted Case Management - In CMHC (TCM)	16 / 15 min units day	$35.00
H052	Medical Evaluation and Management for Established Patient/Subsequent PDE (MD)	Encounter	$124.00 / I (00) $131.00 / I (GT) $244.00 (00) $262.00 (GT) $392.00 (00) $390.00 (GT)
H053	Medical Evaluation and Management for Established Patient/Subsequent PDE (APRN)	Encounter	$66.00/1 $130.00/1 $193.00/1
H056	Psychosocial Rehabilitation Services PRS	24 / 15 min units day	$20. RN (DTD) $11. MHP (0H0) $10. BA (DHN) $10. LPN (DTE) $7. ≤ BA (DHM)
H057	Family Support - **Children Only**	32 / 15 min units day	$43 RN (DTO) $40. MHP (DHO) $38 BA (DHN)
H058	Behavior Modification - **Children Only**	32 / 15 min units day	$40 MHP (DHO) $38 BA (DHM)
H059	Peer Support Services	16 / 15 min units day	$14.00 ≤ BA (DHM)
H060-001	Service Plan Development Interdisciplinary Team with Patient (SPDIT)	1 /Encounter (unit) day up to 6/ Encounters 12 mos	$80.00
H060-002	Service Plan Development Interdisciplinary Team without Patient (SPDIT-NC)	1 /Encounter (unit) day up to 6/ Encounters 12 mos	$80.00
H065	(PRTF) Respite	15/28	$6.00
H066	(PRTF) Service Plan Development	15/100	$37.00
H067	(PRTF) Co-Occurring Group	30/100	$43.00
H068	(PRTF) Intensive Family Service	30/100	$38.00
H069	(PRTF) Prevocational Services	60/100	$23.00
H070	(PRTF) Respite Not in home	flat rate	$157.00
H071	(PRTF) Medication Monitoring/Wellness Education	30/100	$43.00

NEW PATIENT INFORMATION

INFORMATION ABOUT THE PATIENT (please complete all fields)

Last Name:________________________________ First Name_____________________ MI _______

Residence Street Address: ____

City State Zip: ____

Mailing Address: ____

City State Zip:____

Home Phone #:_____________________________ Cell/Work #: _____________________________

Social Security Number: __________________________________ Date of Birth: _________

Race: __ American Indian/Alaska Native __Asian __Black/African American __More than one Race __White

Ethnicity: __Cuban __Mexican/Mexican American __Not Hispanic __ Puerto Rican

Sex: Male __ Female: ___ Marital Status: __Single __Married __Divorced __Widowed __Separated

How many people live in household: _________ How many children live in the home: ______________

Current/Highest level of Education: ________ School Attending:____________________________

Religion: ___________________________________ Registered to Vote: ___Yes ___No

Please indicate areas in which you may require accommodations:

____Hearing ____Speech ____Vision ____Walking ___Language: Preference: ______________

Are you a Veteran: ______________ Branch of Service:_______________________________________

EMERGENCY CONTACT PERSON / NEXT OF KIN

Last Name:_____________________________ First Name:__________________________________

Address:____ City,ST,Zip___________________________

Relationship to patient: __________________________ Phone: ________________________________

FINANCIAL INFORMATION

(Person responsible for the bill if Insurance/Medicare/Medicaid does not pay?)

Last Name: ________________________________ First Name: ________________________________

Social Security Number: ____

Address: ____City, State, Zip:_____________________________

Relationship to Patient: ____

Phone Numbers: Home __________________________ Cell __________________________

HOUSEHOLD EMPLOYMENT/INCOME

Is anyone in the household receiving any of the following? If you answer "Yes", please provide supporting documentation.

Food Stamps: ____ Monthly Amount: ________ Social Security: ____ Monthly Amount: ________

Medicaid #: ________________________________ Medicare #: ________________________________

Wages: ____________________ Weekly/Bi Monthly/Monthly/Yearly # Supported by Income: ____________

INSURANCE INFORMATION:

Insurance Company Name: ____

Insured's Name: ____ Place of Employment: ___________________

Relationship to patient: ______________________ Insured's Date of Birth: _____________________