KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES. & KCIOP

Thank you for choosing Kansas City Psychiatric & Psychological Services, LLC and the KC IOP as your health care provider.

The following is a statement of our **Financial Policy**.

IF YOU HAVE HEALTH INSURANCE COVERAGE…

- You are responsible to supply us with the correct, current insurance information.
- Please notify us of any changes in your address and telephone number.
- ALL copays are due at the time of service.
- Your estimated portion, including any deductibles, will be expected at the time of service.
- You may not pay self-pay, and then ask us to file your insurance at a later time.
- You are ultimately responsible for payment of all charges whether or not such charges are covered and paid (either fully or partially) by your insurance company.

IF YOU DO NOT HAVE HEALTH INSURANCE….

- Payment in full is due at the time of service.
- We accept cash, check, VISA, MC, Discover, American Express.

Our business office is available from 9:00am-5:00pm Monday through Friday to answer any questions or address any concerns you have. If you receive a statement from our office, then we expect payment from you. If you disagree with the balance for any reason, please contact our business office immediately at 816-373-6433.

A parent who brings a minor child to our office for medical care is responsible for payment of all of the child's charges.

I hereby guarantee payment of all charges for medical treatment and services provided to me (or my dependent) by Kansas City Psychiatric & Psychological Services, LLC. I understand and agree that if the office places my account with an agency or attorney for collection, the office shall be paid by me for all collection costs to the extent allowed by applicable law.

I HAVE READ AND AGREE TO THIS FINANCIAL POLICY:

_____

Signature of Patient or Responsible Party

DATE: _____

******Credit/Debit Card Policy******

Patient Name_____

I understand it is the policy of Kansas City Psychiatric & Psychological Services, LLC to secure my credit or debit card information at the time of my visit. The office acknowledges that we must comply with all the provisions of U.S. law.

IF, after a claim has been submitted to my insurance carrier:
1) the claim is denied for any reason; OR
2) there is patient liability (i.e. Deductible, Co-insurance, etc.);
The office will send a statement notifying me of the balance due. If this amount is not paid within 30 days, then my credit or debit card will be charged for the ENTIRE BALANCE owed for treatment of services provided to me or my dependent.

I understand my insurance company will also provide notification of these charges with an explanation of benefits. In the event this amount exceeds $250, the office will provide a courtesy call to the phone number listed on paperwork, leaving a message if we do not reach you.

I understand that in the event my credit or debit card has been charged for medical treatment or services, and then my insurance carrier subsequently makes payment to the office for those charges, the office will issue a credit to my credit or debit card.

Please circle one of the following:

VISA/ MC / Discover / American Express/Checking account/Savings Account

16 digits of credit card #: _____

Expiration Date: _____ 3 Digit Code: _____

Name of Card Holder: _____

Address (Just #): _____ Zip code: _____

Checking or Savings Account #: _____

Bank Routing #: _____

I hereby authorize Kansas City Psychiatric & Psychological Services, LLC and its designated employees to charge my credit/debit card as designated above, the patient responsibility and/or denied amount for any no show or late cancellation fees, medical treatment and services provided by the office. The charge will be based on the medical treatment rendered to my (or my dependent) and the usual and customary charges made by the office for such treatment and service. If the payment is denied by my credit or debit card company, I will pay the entire amount within 30 days.

_____ _____

Cardholder's Signature **Date**

Lee's Summit
120 SW 2nd St., Ste 109
Lee's Summit, MO 64063

Kansas City Psychiatric & Psychological Services & KCIOP
4731 S. Cochise Dr., Ste 206 • Independence, MO 64055
816.373.6433 / Fax: 816.478.9008

Independence
4731 S. Cochise Dr., Ste 206
Independence, MO 64055

ADMISSION WORKSHEET

CLIENT (PATIENT) INFORMATION

TODAY'S DATE: _____ REFERRED BY: _____

PATIENT NAME: _____
(FIRST NAME) (M.I.) (LAST NAME)

DOB: _____ AGE: _____ RACE: _____ MARITAL STATUS: _____ SEX: _____

ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

BEST PHONE (_____)_____ OTHER PHONE (_____)_____
CAN WE LEAVE A REMINDER MESSAGE ON YOUR "Best Phone"? YES or NO _____

SOCIAL SECURITY # _____--____--_____ EMPLOYER: _____EMAIL: _____

PARENT INFORMATION (if patient is a Minor)

FATHER'S NAME: _____ DOB: _____

ADDRESS (**if different from patient**): _____
CITY: _____STATE: _____ ZIP: _____ HOME # (____)_____

MOTHER'S NAME: _____ DOB: _____

ADDRESS (**if different from patient**): _____
CITY: _____STATE: _____ ZIP: _____ HOME # (____)_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE: _____INSUR PHONE_____

CERTIFICATE/POLICY # _____ GROUP # _____

POLICY HOLDER NAME & ADDRESS: _____

DATE OF BIRTH: _____ RELATION TO PATIENT: _____

SOCIAL SECURITY # _____--_____--_____ WORK # (_____)_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE: _____INSURANCE PHONE: _____

CERTIFICATE/POLICY # _____GROUP #_____
POLICY HOLDER NAME: _____

DATE OF BIRTH: _____ RELATION TO PATIENT: _____
SOCIAL SECURITY # _____--_____--_____ WORK # (____)_____

EMERGENCY CONTACT

NAME: _____RELATIONSHIP: _____
PHONE # (_____)_____ OK TO CONTACT? YES or NO _____

KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES AND KCIOP FEES

DATE: _____ PATIENT NAME: _____

COPAYMENTS ARE DUE AT TIME OF SERVICE! NO EXCEPTIONS!

24 HOUR CANCELLATION POLICY: To cancel an appointment you must call and speak with a staff member **24 HOURS PRIOR** to your scheduled appointment.

LATE CANCELLATION FEE: Patient appointments not cancelled or rescheduled within 24 hours of the scheduled appointment will be charged $50.

NO SHOW FEE: Failure to make an appointment will result in a $50

AFTER HOURS EMERGENCY LINE: There will be a charge for any calls made after hours, the charge may vary.

SERVICE CHARGES: There will be a charge for all **Letters** ($25-$50), **FMLA Paperwork** ($50-$100), **Social Security Disability Paperwork** ($300), **Guardianship Letter** ($300), **Medical Records** (flat rate of $22.82, then $.53 per page), **Retrieve Patient's Chart From Storage** ($25, rush fee $75), **Return Check Charge** ($30), **Interest Charges** (charges will vary), interest will be from past due balances or if your account is sent to collections. 10% interest will be added monthly on past due balances. 25% interest will be added to your account if it's turned over to KCI.

ATTENTION IOP AFTERCARE PATIENTS: After successful completion of the program, we provide free aftercare one night a week for the 4 weeks immediately following discharge. Should you choose to come back for aftercare beyond the 4 free visits, you can do so for a fee of $30. This is not billed to insurance.

PAYMENT OF BALANCE DUE: In exceptional cases a balance may accrue. Balances must be paid prior to being seen by a provider. Any account not paid within 30 days will be considered delinquent and will be turned over to our collection agency. When it is necessary our office will work out a payment plan with you. No account will be turned over to collections if a payment plan is in effect. You must be making monthly payments in accordance with the payment plan arrangement to avoid having your account sent to collections.

I have read and agree to comply with the payment conditions listed above.

_____ _____

(Patient Signature / Legal Guardian) Date

KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC

INFORMED CONSENT FOR TREATMENT & CONFIDENTIALITY

I _____ understand that as a patient of KCPPS I am eligible to receive a range of services. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me.

I understand that all information shared with the clinicians at KCPPS is confidential and no information will be released without my consent. While written authorization will not be requested, prior to any discussion with any other health care provider, I understand that my provider will discuss KCPPS communications with me. In all other circumstances, consent to release information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is a risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provides KCPPS services. All professionals-in-training are supervised by licensed staff.
I understand that violence of any kind will not be tolerated and will be grounds for immediate discharge. I also understand that if I am non-compliant with the treatment plan discussed with my provider that may be grounds for discharge.
I understand that while psychotherapy and/or medication, may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.
If I have any questions regarding this consent form or about the services offered at KCPPS, I may discuss them with my therapist. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by KCPPS. I understand that I may stop treatment at any time.

ASSIGNMENT OF BENEFITS

I hereby assign and convey directly to KCPPS, as my designated authorized representative, all medical benefits and/or insurance reimbursement. If any payments are made to me in error from the insurance company for services provided to me by KCPPS, I understand that I am financially responsible for all charges regardless of any insurance payments.

_____ _____

Client/Guardian signature indicating full understanding Date

KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC

NAME:_____AGE:___DOB: _____grade:_____

Height:_____Weight: _____Gender expression/Sexual Orientation:_____

What prompted you to seek mental health services? _____

Have you been treated for this problem in the past? _____

Was the treatment helpful? _____

Do you have a history of trauma that you have experienced? examples: abuse, neglect, sexual assault, violence

_____

Have you ever been a witness to trauma? _____

Have you been diagnosed with any medical conditions?_____

List previous illnesses: _____

List previous surgeries: _____

List all hospitalization & dates: _____

Have you ever attempted suicide? _____When?_____

Are you currently experiencing suicidal thoughts and/or homicidal thoughts or have you had them in the past?

_____

_____

List all medications you are currently taking: _____

Do you have allergies?_____If so, what are they: _____

Do you smoke?_____If so, how many a day? _____

Do you drink alcohol?_____If so, how much/how often? _____

Do you use drugs?_____If so, how much/how often? _____

Have you ever received treatment for drug/alcohol abuse? _____

If so, where/dates: _____

Who is your Primary Care Physician (PCP)? _____

Date of last visit (PCP)? _____Is your PCP aware you are seeking treatment: Yes/No

KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC

PATIENT EDUCATION AND SELF EVALUATION

What do you consider your Strengths?: _____

What do you feel are your urgent needs or weaknesses at this time?:_____

What are some of your Abilities/Interests: _____

Preferences for treatment/learning: (please circle)
Verbal Written Audio/Video Hands-on Group discussion Individual

Other not listed: _____

Employment History: _____

Highest level of education: _____

What is the primary language you speak? _____

Legal history and/or current charges pending: _____

Military History: _____

Do you need any special assistance to help you learn? (please circle)
Communication board Deaf Interpretor Language Interpretor Other_____

Complementary/Alternative treatments tried? (i.e. yoga, meditation, relaxation, acupuncture) _____

Do you have any Spiritual beliefs and/or cultural info you would like us to know: _____

List 3 goals for your treatment here: _____

_____

Who is your support system?_____

KANSAS CITY PSYCHIATRIC & PSYCHOLOGICAL SERVICES, LLC

CHILD/ADOLESCENT ADDENDUM

1. **IMMUNIZATION HISTORY/CURRENT?**
   - ⧫ DPT YES_____NO_____DATE:_____/_____/
   - ⧫ POLIO YES_____NO_____DATE:_____/_____/
   - ⧫ MMR YES_____ NO_____DATE:_____/_____/
2. **SPECIAL CONSIDERATION?**
   PRIMARY LANGUAGE OTHER THAN ENGLISH: _____ NICKNAME: _____ FAVORITE
   TOYS, GAMES, HOBBIES OR INTEREST:
3. **SLEEPING HABITS (CHILD ONLY) BEDTIME?_____**
   NAP TIME? _____ ARISING TIME? _____ LIGHT LEFT ON?
   □ YES □ NO
   NIGHTMARES? □ YES □ NO
4. **ADDITIONAL INFORMATION (CHILD ONLY)**
   - A. **FAVORITE FOODS?**
   - B. **DOES YOUR CHILD FEE HIM/HER SELF? □ YES □ NO**
   - C. **AGE WALKED?**
   - D. **TOIET TRAINED? □ YES □ NO IF YES, WHAT AGE?**
   - E. **TERM USED FOR URINATION/BOWEL MOVEMENT:**
   - F. **WHAT HAVE YOU TOLD YOUR CHILD ABOUT THIS TREATMENT?**
   - G. **REACTION TO PAIN/FRIGHT?**
   - H. **HOW DO YOU DISIPLINE YOUR CHILD?**
   - I. **OTHER HELPFUL INFO ABOUT YOUR CHILD:**
5. **DEVELOPMENT STATES 4-5 YEARS**
   - ⧫ KNOWS FIRST & LAST NAME
   - ⧫ INERACTS WITH OTHERS IN PLAY
   - ⧫ HOPS OR SKIPS
   - ⧫TOLERATES SEPERATIONS FOR A FEW MINUTES FROM PARENTS

   6-9 YEARS
   - ⧫ BATHES, DRESSES, COMBS HAIR
   - ⧫ ASSUMES RESPONSIBILITY
   - ⧫ HOUSEHOLD CHORES
   - ⧫ EXPRESSESS HIS/HER NEEDS
   - ⧫ PLAYS GAMES WITH OTHER KIDS
   - ⧫ CAN COOPERATE IN ACTIVITIES

   9-12 YEARS
   - ⧫ HAS BEST FRIEND
   - ⧫ READS NEWSPAPER/MAGAZINES
   - ⧫ ASSUMES RESPONSIBILITY FOR SELF & BELONGINGS
   - ⧫ HAS A HOBBY
   - ⧫ INVOLVED IN FAMILY DECISIONS

   13-17 YEARS
   - ⧫ PEER GROUP INVOLVEMNET
   - ⧫ INVOLVEMENT IN GROUP SPORTS, SOCIAL ACTIVITIES, SCHOOL ACTIVITIES, ETC.
   - ⧫ DEMONSTRATING INDEPENDENT DECISION MAKING
   - ⧫ DEMONSTRATING INTEREST IN FUTURE CAREER GOALS
6. **CONTINUING CARE INFORMATION**
   SPECIAL REQUEST: _____
   EXPECTATIONS FOR DISCHARGE: _____ ANTICIPATED NEEDS/SERVICES/EQUIPMENT: _____

Kansas City Psychiatric and Psychological Services, LLC (KCPPS)

MEDICARE & MEDICAID WAIVER FORM

EVEN IF YOU DO NOT HAVE MEDICARE OR MEDICAID YOU MUST INITIAL & SIGN THIS FORM

Please initial each section to verify you have read and understand:

_____I understand that Kansas City Psychiatric & Psychological Services, LLC is not contracted with Medicare or Medicaid insurance.

_____I understand that Medicare/Medicaid limits do not apply to any charges that are incurred by my physician or counselor at KCPPS.

_____I understand that KCPPS will NOT bill claims to Medicare/Medicaid and that no payment will be made from Medicare/Medicaid to KCPPS for services provided to me.

_____I understand that I can seek services from another provider that is contracted with my insurance and that I am choosing to be seen here at KCPPS.

_____I am aware and take full responsibility for any and all charges that are incurred for services, paperwork, records, phone consults, no show fees, etc.

_____I agree to pay in full for these fees at time of service.

DATE: _____

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

Social Security #: _____

Signature of Patient/Legal Guardian: _____