MEMOR HEALTH – PATIENT INFORMATION

PATIENT INFORMATION:

Last Name: First Name:

Middle Name: Preferred Name:

Date of Birth: Social Security Number: - -

Physical Address:
Street

City State Zip Code

Mailing Address:
Street

City State Zip Code

Home Phone: ( ) - Cell Phone: ( ) -

Email Address:

Employer: Work Phone: ( ) -

Sex (needs to match what is indicated on your insurance): ☐ Male ☐ Female

Gender (if applicable): ☐ Transgender ☐ Non-binary

☐ Other (please explain):

Preferred Pronouns (if applicable): ☐ He/Him ☐ She/Her ☐ They/Them

☐ Other (please explain):

MEMOR HEALTH – PATIENT INFORMATION

EMERGENCY CONTACT:

Name: Relationship to patient:

Home Phone: ( ) - Cell Phone: ( ) -

IF PATIENT IS A MINOR (OR HAS A LEGAL GUARDIAN)

Parent/Legal Guardian Name:

Address:

Street

City State Zip Code

Home Phone: ( ) - Work Phone: ( ) -

Cell Phone: ( ) -

Parent/Legal Guardian Name:

Address:

Street

City State Zip Code

Home Phone: ( ) - Work Phone: ( ) -

Cell Phone: ( ) -

MEMOR HEALTH – PATIENT INSURANCE INFORMATION

Primary Insurance Name: _____

ID Number: _____ Group number: _____

Name of Primary Insured: _____

Patient's Relationship to Primary Insured: _____

Primary's SSN: _____ Primary's DOB: _____

Primary's Employer: _____ Employer's Phone: _____

Secondary Insurance Name: _____

ID Number: _____ Group Number: _____

Name of Secondary Insured _____

Patient's Relationship to Secondary Insured: _____

Secondary's SSN: _____ Secondary's DOB: _____

Secondary's Employer: _____ Employer's Phone: _____

Name of Patient's Primary Care Physician (PCP) _____

PCP phone: _____

PCP address: _____

I certify that the above patient and insurance information is true and correct. I understand that it is my responsibility to notify Memor Health of any changes in any of the information listed above. I authorize Memor Health to release any medical or other information necessary to process my claims and payment of benefits to my insurance carrier(s).

_____ _____

Patient/Guardian Signature ***Date***

_____

Patient Name (Printed)

GENERAL CONSENT FOR TREATMENT

A. CONSENT FOR TREATMENT_____(initial)

I, the undersigned or responsible party, hereby consents to treatment by Memor Health and all providers contracted with it, including examination, developing a treatment plan, administration of medication, and other treatment modalities as ordered by the physician or provider.

B. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION_____ (intial)

My consent and authorization is hereby granted to Memor Health and it's contracted providers, to release to healthcare facilities providing subsequent care, my insurance companies, health maintenance organizations, preferred provider organizations, medical trust fund, medical plan, my employers self-funded medical plan, third party administrators, other third party payers (which pay or may possibly pay any portion of the charges for my medical/health care) and any of their authorized agents, my confidential health and medical information, including copies of my medical records as may be requested or necessary for, including but not limited to the verification of my treatment, quality assurance/improvement functions, utilization management, discharge planning, other medical audits or as necessary for Memor Health or any of my payors to comply will all applicable federal and state laws, rules and regulations, and accrediting bodies. This consent and authorization is ongoing, unless revoked by the patient in accordance with paragraph C below. I hereby release and hold harmless on behalf of myself, my heirs, executors, assigns and administrators, Memor Health and its contracted providers, employees and agents from any and all liability or damage occasioned by such good faith release. **I understand that I have the right to access my records, but psychotherapy notes are the exception under the law.** I understand that there is a fee attached to the release of my records.

C. REVOCATION OF CONSENT_____ (initial)

I understand that I have the right to revoke this consent in writing, except to the extent that the organization and or its providers has already acted in reliance thereon. I also understand that I have the right to object to the use of my health information for directory purposes and the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations. The organization and/or its providers are not required to agree to the restrictions requested and in any event, may release records to subsequent medical providers when deemed necessary and important for the continuing care of the patients.

D. PAYMENT_____ (initial)

I understand that payment is expected at the time of my visit. Memor Health accepts cash and credit cards (**no** checks).

E. ASSIGNMENT OF INSURANCE BENEFITS_____ (initial)

The undersigned and if more than one, jointly and separately, hereby authorizes payment directly to Memor Health or to its contracted providers otherwise payable to him/her or due to become payable to him/her, for all charges incurred during this/these office encounter(s). I understand that I am ultimately responsible for all unpaid charges including those that may fall outside of the terms and conditions of a plan. These may include **services that are subject to an additional fee** such as telephone consultations time, letters, and medical records for an outside source, detailed report preparation, and collaboration with a therapist, school official or teacher. The undersigned

agrees to pay an additional amount of fee for copay or other such payments that are expected and not paid at the time of service or within a certain time limit. I understand that the organization does not guarantee that my insurance plan will pay; while the organization will make every attempt to verify benefits and to determine my liability. I note that the Memor Health is not responsible for misinformation provided by the insurance company or their representatives. **Any services rejected by my carrier will be my responsibility.** Payment will remain due and owing for services provided should either party terminate the relationship. I understand that my account will be sent to a **collection agency** if I do not pay in a timely manner.

F. MISSED APPOINTMENTS_____ (initial)

I understand that missed appointments are not only a loss to me, but also to the physician and other patients that could have been seen. Memor Health maintains a No-Show/Cancellation Policy that dictates that appointments which are **not cancelled 48 hours in advance** of the appointment will be assessed a **fee starting at $75.00** (subject to change). If you are more than 5 minutes late to an appointment, the provider may not be able to see you, and this will be considered a late cancellation. This charge is **non-payable by insurance** and is the responsibility of the patient. **Continued No-shows** and/or same day cancellations (usually 3 or more) **may lead to termination of relationship** or referral to another provider. Memor Health understands that emergencies arise and the staff will continue to do their best to accommodate everyone in an urgent situation. **These fees are due at the next scheduled appointment**. **For psychiatry appointments, the fee must be paid prior to rescheduling, and no refills of medications will be prescribed until the fee is paid.**

G. PSYCHIATRY APPOINTMENTS_____ (initial)

If under the care of a psychiatrist at Memor Health, I agree that appointments will be scheduled within the timeframe dictated by my psychiatrist. No appointment should exceed 16 weeks from the last appointment. If you exceed this 16 week limit, refills of medications may be suspended, and the provider may deem it appropriate to discharge you from services at Memor Health.

H. MEDICATION REFILLS_____ (initial)

If I need a medication refill and it is not time for me to be seen, I understand that I should contact the office preferably **3-4 days prior and no less than 48 hours** before running out of medication. This will give the office staff time to obtain authorizations that may be needed and make any changes that may be required.

I. PRIVACY_____ (initial)

I agree to maintain the confidentiality of all other patients of the clinic. Our staff will maintain your confidentiality by not acknowledging you outside of the clinic unless you first acknowledge them.

J. DUTY TO REPORT_____ (initial)

Memor Health has a legal obligation to report to authorities if they believe a child, disabled person, or elderly person is being abused or neglected. Memor Health has a legal obligation to report to authorities if they believe you are an imminent danger to someone else, or an imminent physical, mental or emotional danger to yourself.

K. EMERGENCY SITUATIONS_____ (initial)

In the case of an emergency, call 911 or go to your local emergency room. If you are suicidal, you can call the Crisis Call Center at 800-273-8255. In the case of an emergency situation, or if I am deemed a threat to myself or someone else,

I, _____ (patient name)

give the staff of Memor Health permission to speak with:

_____(name and the relationship to patient along with contact phone number)

L. CHILD CUSTODY EVALUATIONS_____ (initial)

Memor Health will not perform child custody or parenting evaluations.

BY SIGNING THIS AGREEMENT, PATIENT OR PATIENT'S GUARDIAN, HEREBY ATTESTS THAT HE OR SHE HAS READ AND UNDERSTANDS THIS AGREEMENT.

_____ _____

Patient/Guardian Signature ***Date***

_____

Patient Name (Printed)

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

I have received and understand this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

_____ _____

Signature of Patient/Guardian/Responsible Party **Date**

_____

Patient Name (Printed)

<u>The staff of Memor Health has permission to:</u>

Please select the checkbox to the left for the preferred appointment reminder and indicate yes or no to the right for which Memor Health is allowed to contact you for general communication:

☐ **Leave a message on voicemail**	☐ **yes**	☐ **no**	**Phone#** _____
☐ **Leave a message with another person**	☐ **yes**	☐ **no**	**Phone#** _____
☐ **Send a text message**	☐ **yes**	☐ **no**	**Cell #** _____
☐ **Send an email**	☐ **yes**	☐ **no**	**E-mail** _____

PATIENTS RIGHTS AND RESPONSIBILITY STATEMENT

Patients have the right to:

- Be treated with dignity and respect
- Fair treatment; regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Their treatment and other patient information are kept private. Only where permitted by law, may records be released without patient's permission.
- Easily access timely care in a timely manner
- Know about their treatment choices. That is regardless of cost or coverage by the patient's benefit plan.
- Share in developing their treatment plan
- A clear explanation of their condition and treatment options
- Information about clinical guidelines used in providing and managing care.
- Know about advocacy groups and community groups and prevention services.
- Freely file and complaint or appeal.
- Know their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care be made without regard to financial incentives

Statement of Patient's Responsibilities

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Ask questions about their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the provider and the patient.
- Follow the agreed upon medication plan
- Tell their providers and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Patients should call Memor Health as soon as they need to cancel their visits.
- Let the provider know when the treatment plan is not working for them.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities and that I understand this information.

_____ _____

Patient/Guardian signature ***Date***

_____

Patient Name (Printed)

PAST PSYCHIATRIC TREATMENT HISTORY

1. Have you ever been admitted to a psychiatric hospital or facility? ☐yes ☐no
If yes, when and where:

_____

_____

2. Have you ever been admitted to an alcohol/drug treatment program? ☐yes ☐no
If yes, when and where:

_____

3. Have you ever received outpatient psychiatric treatment or therapy/counseling?
☐yes ☐no. If yes, when and where:

_____

_____

4. Have you ever attended any support groups, such as AA or NA? ☐yes ☐no
If yes, when:_____

MEDICAL HISTORY

1. Do you have any chronic medical illnesses? ☐yes ☐no
If yes, please list:_____

_____

2. Are you currently taking any medications? ☐yes ☐no
If yes, please list:_____

_____

3. Have you had major surgery in the past? ☐yes ☐no
If yes, please list:_____

_____

Are you sexually active now? ☐no ☐yes

Have you ever had an HIV test? ☐no ☐yes

Do you smoke cigarettes? ☐no ☐yes; Quantity_____(day)

Do you drink alcohol beverages? ☐no ☐yes; Quantity_____ per ☐week or ☐month

Any adverse/allergic reaction to medications? ☐yes ☐no

If yes, please list the medication(s):_____

When was your last physical exam?_____

(A) Was lab work done? ☐yes ☐no
(B) Was an EKG done? ☐yes ☐no

Overall how would you rate your physical health?

☐*Excellent* ☐*Very Good* ☐*Good* ☐*Fair* ☐*Poor*

PATIENT ACKNOWLEDGEMENT OF PRIVACY POLICY

I understand I have the right to review the document "Memor Health – Notice of Privacy Policy" prior to signing this document. This notice has been provided to me in my intake packet. The notice of Privacy Policy describes the types of uses and disclosures of my "protected Health Information (PHI)" that will occur in my treatment, payment of bills or in the performance of healthcare operations of this clinic. My protected health information means health information including my demographic information (name, address, phone number, etc.) that is collected from me and created or received by this clinic or its agents or employees. PHI is information that relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe that the information may identify me. The Notice also describes other potential releases of my PHI that may occur with or without my authorization, and my rights regarding my PHI. By signing this form, you consent to our use and disclosure of your PHI as specified in the Notice of Privacy Policy, and acknowledge receipt of the Notice.

PLEASE NOTE: Unless you are claiming insurance for your treatments here, your protected health information (PHI) will never be discussed, verbally or in writing, with anyone but you. We will only disclose information to others once we have obtained your express written permission.

I give Memor Health permission to discuss my protected health information, with the following:

_____

If yes, initial

_____	_____	_____
Name	Relationship	Phone number
_____	_____	_____
Name	Relationship	Phone number

I wish to keep my protected health information private.

_____

If yes, initial

I wish to keep my protected health information private. I reserve the right to change this in the future. I understand that the only exception to this is an emergent situation (i.e.; If I am deemed a threat to myself or someone else); but, even then, the only information that will be released is that you are an active patient of Memor Health.

_____ _____

Patient/Guardian Signature **Date**

_____

Patient Name (Printed)

MEMOR HEALTH – FINANCIAL POLICY

Thank you for choosing our practice! It is our belief that establishing a written financial policy is mutually beneficial to all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing excellent healthcare services to our patients.

PAYMENTS AND FEES Out-of-pocket payments, co-payments, deductible amounts, and any outstanding balances are due at the time of service. If the patient is a minor, the parent/guarantor will be responsible for making payment of services. In the case of services provided to patients under the age of 18, the parent, guardian or legal representative ***who initiates*** the services for the minor will be responsible for payment. We do not bill another individual or estranged spouse for payment.

MISSED APPOINTMENTS Memor Health maintains a No-Show/ Cancellation Policy, that dictates that appointments which are not cancelled 48 hours in advance of the appointment will be assessed a fee starting at $75.00 (subject to change). This Charge is non- payable by insurance and is the responsibility of the patient. **This fee must be paid before we can reschedule an appointment for you; if you already have a future appointment scheduled, please note the fee will be due the day of that appointment**.

INSURANCE You can find the list of insurances we accept currently on our website (www.memorhealth.com). If we are a contracted provider for your insurance plan, we will bill the insurance directly. *We do not file claims to any insurance in which we do not participate*. Every insurance policy varies with respect to the specific benefits and coverage provided.

AUTHORIZATIONS The patient must notify Memor Health of any authorizations that are required for services provided by this office. Contact the insurance carrier to determine whether an authorization is needed for outpatient mental health services. If the correct authorization is not acquired prior to the time of service, the patient recognizes that this may result in a denial of coverage, and the balance of the claim will be billed to the patient.

DENIED SERVICES If a service is denied, the balance regarded as the patient's responsibility by the insurance company will be due to the patient. Payment is required even if the patient is disputing the claim with their insurance company.

REFUNDS Refunds are issued on a quarterly basis and only after all balances have been reconciled with Memor Health. Refunds less than $20 need to be requested by the patient. Refunds more than $20 will be mailed to the address on file.

PLEASE REMEMBER: The agreement of the insurance carrier to pay for health care is a contract between you and the insurance company, therefore It is ultimately your responsibility to check with your insurance company to determine covered benefits. Any questions or complaints regarding coverage should be directed to your insurance company.

If your insurance policy changes, please call our office to inform us of your new policy and bring your insurance card with you to your next appointment.

I hereby confirm that I have read the financial policy and understand it.

_____ _____

Patient/Guardian Signature **Date**

_____

Patient Name (Printed)

Notice**

Dr. Yvette Kaunismaki and Dr. Alex Brooks are accepting patients 16 years and older. Although they will treat children as young as 16 years old, they are adult psychiatrists and have had no special training in child or adolescent psychiatry.

In order to treat your child appropriately, they will need to see your child at least every 12 weeks, if not sooner. If a patient is not seen within this timeframe and this happens more than twice, he/she will be discharged due to inability of our psychiatrists to appropriately care for the patient.

By signing below, you are acknowledging the above statement and allowing Dr. Yvette Kaunismaki or Dr. Alex Brooks to treat your child.

_____

Patient Name Printed

_____

Legal Guardian's Name Printed

_____ _____

Legal Guardian's Signature **Date**

**Applies only to adolescent patients of Dr. Kaunismaki and Dr. Brooks