Seaside Behavioral Health

New Patient Information

Name: _____ Date _____

DOB _____SSN _____ Marital Status: S / M / D / W

Address _____
Street City State Zip Code

Email Address _____ OK to use? Y / N

Home Phone _____ OK to leave message? Y / N

Cell Phone _____ OK to leave message? Y / N

Occupation _____ Hours worked per week? _____

Employer (School if Student) _____

Employer Address _____

Employer Phone _____ OK to call? Y / N

INSURANCE: (Please present all Insurance Cards to the Receptionist and bring them to EVERY appointment. Please remember that ALL copays/cost shares and deductibles are due at the time of service)

Insurance: 1._____ 2. _____ 3. _____

Policy ID/
Group #: 1._____ 2. _____ 3. _____

Policyholder
Name: 1._____ 2. _____ 3. _____

Policyholder
DOB: 1._____ 2. _____ 3. _____

Policyholder
SSN: 1._____ 2. _____ 3. _____

Pharmacy Card Name and Number: (If applicable) _____

IF ANOTHER PERSON IS RESPONSIBLE FOR CHARGES:

Name _____ Relationship _____

Address _____

Home Phone _____Cell Phone _____ Work Phone _____

EMERGENCY CONTACT INFORMATION:

Name _____ Relationship _____

Address _____

Home Phone _____Cell Phone _____ Work Phone _____

Email to seasidebhvb@gmail.com or fax to 757.648.1363

Seaside Behavioral Health

Medical History

Primary Care Provider Can we contact? Y / N

Name _____

Address _____

Phone _____ Fax Number _____

Date of Last Visit _____ Frequency of Visits _____

Current Medications (include nutritional supplements, herbal supplements and over-the-counter medications) ☐ None

Name of Medication & Approximate Start Date	Dose	Frequency	Reason Prescribed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If there are additional medications, please attach a complete list.

Allergies (medication and food) and reactions: ☐ None

_____

_____

Height: _____ Weight: _____

Drug and Alcohol History:	Amount	Frequency	Most Recent Use
Cigarette/Other Tobacco Products:	_____	_____	_____
Alcohol:	_____	_____	_____
THC / Cannabis (specify if for medical use):	_____	_____	_____
Opioids (specify if for medical use):	_____	_____	_____

Other (explain): _____

Notes: _____

_____

Have You Ever Had: Please review and check all that apply. ☐ None of the following

☐ Seizures ☐ Fracture or Severe Injury Blackouts ☐ Chest Pains ☐ Head Injury / Concussion

☐ Fainting Spells ☐ Shortness of Breath / Asthma ☐ Heart Palpitations ☐ Eating Disorders (explain)

☐ Any relevant legal issues: _____

Notes:_____

Email to seasidebhvb@gmail.com or fax to 757.648.1363

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Medical History (cont.)

Medical Conditions: (Please list all medical conditions you have been treated for) ☐ None

_____ _____ _____

_____ _____ _____

History of Abuse: (any physical, sexual, emotional, etc.) ☐ None

_____

_____

Hospitalizations / Surgeries: (please include psychiatric hospitalizations, partial hospitalizations, intensive outpatient programs, as well as dates)

☐ None _____

_____

_____

Past Psychiatric Medications and Response to Medication: ☐ None

_____

_____

_____

Family Psychiatric History: (include relative, illness, treatment, etc) ☐ None

_____

_____

_____

Former Psychiatrist and Therapist: (Please list name, address and phone number) ☐ None

_____ _____

_____ _____

_____ _____

How did you hear about Seaside Behavioral Health? _____

What is the reason for your visit today? ☐ Medication Management ☐ Individual Therapy ☐ Referral

Other notes for your visit:

_____

Email to seasidebhvb@gmail.com or fax to 757.648.1363

Seaside Behavioral Health

Patient Consent

Please initial:

_____ **Confidentiality**
I have read and understand the privacy practices for Seaside Behavioral Health. I have been offered a copy of the Health Insurance Portability Accountability Act (HIPAA) information. If I have any questions at any time, I will bring them to the attention of the Seaside Behavioral Health Staff.

_____ **Limits of Confidentiality**
I agree to the limits of confidentiality and understand their meanings and ramifications.

_____ **Cancellation Agreement**
I agree to be financially responsible for missed appointments and/or appointments cancelled with less than 24 hours notice.

_____**Fee Schedule / Cost Share**
I agree and understand the fee schedule and that all copays, cost share and deductibles are payable by me at the time services are rendered. I agree to pay any balance not received by my insurance carrier in a timely manner.

_____**Medication and Refill Policy**
I agree to and understand the medication and refill policy.

Consent to Treat

I, _____, have read the policies and procedures of Seaside Behavioral Health and give consent for evaluation and treatment.

_____ _____
Patient's Name Date

_____
Name of Parent or Guardian of Minor Patient and Relationship

_____
Signature of Patient (Parent or Guardian if Patient is under 18

_____
Witness

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Fee Schedule and Appointments

It is your responsibility to provide Seaside Behavioral Health with the correct insurance policy at the time services are rendered. We request that you have your insurance cards with you at each visit. We will be happy to file with your insurance carrier for you however you are responsible for your portion of payment at the time of service and any insurance balance due if not received during timely filing guidelines. We accept cash and major credit cards (Visa, Master Card and Discover).

The following is a list of services that are not covered by insurance and you will be responsible for payment at the time of occurrence:

FMLA or Disability Forms / Standard Letters: Starting at $35.00
Complete Medical Evaluation for Legal/Disability Benefits: Starting at $125.00
Court Appearance: Starting at $150.00 hour (min 2hrs)
Copy / Transfer of Medical Records: $0.50 per page first 50, $0.25 per page 51+ page
$10.00 postage / search and handling
(Virginia State Statue 8.04-413)

These charges are payable at the time that services are rendered or upon notice by Seaside Behavioral Health.

Cancellation Policy
We understand that situations may arise in which you will not be able to keep an appointment. Should you have to cancel or reschedule please give 24-hour notice. No-shows or appointments not cancelled with 24-hour notice are subject to a $70 charge for therapy sessions or $50 for brief medication appointments. A New Patient appointment that is cancelled the same day will require a $100 fee paid prior to rescheduling.

Appointments
Our staff is available to make appointments Monday through Friday from 9am – 5pm. Our Providers office hours vary, our staff can assist you to schedule a time that works for you and the provider. Same day appointments can be accommodated if space is available. You will receive an email reminder one week in advance and the day before your appointment. We work with Practice Fusion so the email/text will come from Patient Fusion.

Medication and Refill Policy

In order to effectively manage your medication, please be aware that the following guidelines need to be followed:

1. To receive refills of your medication(s) you must be seen regularly by your provider. Your provider will determine the frequency of your appointments.
2. Please contact the office immediately if experiencing any intolerable/unexpected side effects of your medication.
3. Please notify the office any time another physician starts or changes your medications or there is change in your health status. This is important as certain medications or illness can alter the effect of the prescribed medication and adjustments may need to be made.
4. Please anticipate any refill needs and address it during your office visit. Refill request from pharmacies are not honored and you must call the office and speak with our staff. Refills cannot be done on weekends or holidays.
5. Requests for refills may take up to 48 hours to be available at your pharmacy.

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Limits of Confidentiality

Seaside Behavioral Health values and respects the privacy of all their patients and considers all therapy sessions to be confidential. Both verbal and written information about the patient cannot be shared without consent of the patient or patient's legal guardian. The following are exceptions to this confidentiality as outlined by the American Psychiatric Association.

Duty to Warn and Protect
When there is good reason to believe an individual is threatening serious bodily harm to another person. Seaside Behavioral Health is required to warn the intended victim and report this information to authorities. In the event an individual discloses or implies a plan for suicide, Seaside Behavioral Health is required to notify legal authorities and make reasonable attempts to notify the patient's emergency contact.

Abuse of Children and Vulnerable Adults
If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, Seaside Behavioral Health is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Seaside Behavioral Health is required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minor / Guardianship
Parents or legal guardians of non-emancipated minor patients have the right to access the patients' records.

Insurance Providers
Insurance companies and other third-party payers are given information that they request regarding services to patients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries.

Other Limits of Confidentiality
In response to a court order, or where otherwise required by law.
To the extent necessary for emergency medical care to be rendered.
To the extent necessary to make a claim on a delinquent account via a collection agency.

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Notice of Privacy Acts

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended from time to time.

Our Responsibilities

We understand that information about you and your health is personal and sensitive in nature. We are committed to protecting the privacy of this information. Our primary responsibility for your personal health information is to keep it safe. We must also give you notice of privacy practices, and we must follow the terms of the notice.

Protected Health Information

Protected Health Information (PHI) is demographic and individually identifiable health information that will or may identify the patient and related to the patient's past, present, or future physical and mental health or condition and related health care services.

Medical Information

At Seaside Behavioral Health, your records are used as a way of recording health information, planning care and treatment and as a tool for routing health care operations. Insurance companies are involved in reimbursing for payments for services; they may request information such as procedure and diagnostic information. Information that may identify you will not be released to anyone without your written authorization from you or your parent/legal guardian.

Medical information may be used to justify patient care services (i.e. lab texts, prescriptions). We will use medical information to establish a treatment plan. We may use the emergency contact information you provided to contact you if address and phone number of record is no longer accurate. We may contact you to remind you of your appointment by phone, text or email. We may contact you to discuss treatment alternatives or other health related benefits that may be of interest.

Minors- If you are an un-emancipated minor under Virginia law, there may be circumstances in which we disclose health information about you to a parent or guardian in accordance with legal and ethical responsibilities.

Parents- If you are a parent or guardian of an un-emancipated minor, and are acting as the minor's personal representative, we may disclose health information about your child to you under certain circumstances.

Patient Rights

As a patient at Seaside Behavioral Health, you have the right to:

- **Request a restriction on certain uses of your protected health information.** We are not required by law to agree to your request.
- **Obtain a paper copy of this Notice of Privacy Practices upon request.** You may ask us to restrict or limit the medical information we use or disclose for the purposes of treatment, payment, or healthcare operations. We are not required to agree to a restriction that you may request. We will notify you if we deny your request. If we do agree to the requested restriction, we may not disclose your PHI in violation of the restriction unless it is needed to provide emergency treatment or required by law.
- **Inspect and request a copy of your protected health information for a fee.** This includes medical and billing records and any other records that we use in making decisions about your healthcare. This does not include however, psychotherapy and psychosocial notes; information complied in reasonable anticipation of, or use

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- in, a civil, criminal, or administrative action or proceeding, and certain PHI that is subject to laws that prohibit access to that PHI. Please contact our Practice Administrator if you have any questions about access to your medical records.
- **Request an amendment to your health records** if you feel the information is incorrect or incomplete. We may deny your request for an amendment if:
    - it is not in writing,
    - it does not include a reason to support the request,
    - the information was not created by our practice,
    - it is not part of the information kept by our practice,
    - it is not part of the information which you would be permitted to inspect and copy, • the information already in the records is accurate and complete.

  Please note that even if we accept your request, we are not required to delete any information from your health record. If we disagree with your request you have the right to submit a statement of disagreement to be enclosed with future releases of the information in question.
- **Obtain a record of the sharing/disclosures of your health information.** The record will only list information shared for purposes other than treatment, payment or healthcare operations and will exclude information that was shared because of a valid authorization.
- **Request communication of your health information by alternative means or to alternative locations.** We will honor reasonable requests when you provide the alternative address/contact information and information on how payment will be handled.
- **Revoke your authorization** to use or share health information except to the extent that action has already been taken. To revoke or cancel this authorization, you must submit your request in writing to Seaside Behavioral Health.
- **Understanding your rights.** Please notify our Practice Administrator if you don't understand this authorization. He/She will gladly explain it to you.
    - **Refuse to sign authorization.** Your refusal will not affect your ability to obtain treatment. If you refuse to sign this authorization Seaside Behavioral Health has the right to decide not to treat you or accept you as a patient in the practice.

Disclosure of Psychotherapy Notes

HIPPA provided special protections of certain medical records known as "Psychotherapy Notes". All psychotherapy notes recorded on any medium (i.e. paper, electronic) by the provider must be kept by the author and filed separate from the rest of the patient's medical records to maintain a higher standard of protection. HIPAA defines "Psychotherapy Notes" as notes recorded by a health care provider who is a mental professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and the progress to date. Written authorization is required by the patient to specifically allow for the release of "Psychotherapy Notes" to a third party.

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Notice of Privacy Acts

Acknowledgement

I understand I have the right to review Seaside Behavioral Health Notice of Privacy Practices prior to signing this document. The Notice of Privacy Acts describes the types of uses and disclosure of my protected health information that will occur in my treatment, payment of my statements or in the performance of health care operations of Seaside Behavioral Health. The Notice of Privacy Acts for Seaside Behavioral Health is also provided on the Seaside Behavioral Health website at www.seasidebh.com. The Notice of Privacy Acts also describes my rights and the duties of Seaside Behavioral Health with respect to my protected health information. Seaside Behavioral Health reserves the right to change the privacy practices that are described in the Notice of Privacy Acts. I may obtain a revised notice by accessing the Seaside Behavioral Health website, calling the office and requesting a revised copy to be sent my mail, or asking for one at the time of my next appointment. A copy of the current notice will also be posted in the practice.

_____ _____

Patient's Name Date

_____

Relationship to Patient

_____

Signature of Patient (Parent or Legal Guardian if patient is under 18)