Patient Information

Date:_____ Social Security # :_____

Patient's Name (First)_____(MI)_____(Last)_____

Birthdate: _____Age: _____Sex: ☐ Male ☐ Female

Home Address: _____City: _____ State: _____Zip: _____

Home Telephone: (_____)_____Cellphone Number: (_____)_____

Check if ok to Leave Voicemail at these numbers ☐

Employer Name: _____Work Telephone: (_____)_____

Pharmacy of Choice: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Guardian information/ Emergency Contact Information

Name: _____Telephone Number: _____

Employer Name:_____Telephone Number:_____

Relationship to Patient: ☐ Child ☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Billing (Card Holder) Information

Name:_____ Birthdate:_____Social Security Number:_____

Relationship to Patient:☐ Child☐ Spouse ☐ Mother ☐ Father ☐ Other: _____

Insurance Information

Primary Insurance Information	Secondary Insurance Information
Company: _____	Company: _____
Address: _____	Address: _____
Insurer Name:_____	Insurer Name:_____
ID#:_____	ID#:_____
Group #_____	Group #:_____

AUTHORIZATIONS:

Consent to treatment: *I hereby grant consent for treatment or services to be provided by a New Perspectives clinician. I also certify that no guarantee/assurance has been made as to the results which may be obtained.*

Release of medical information: *I consent to the release of my records by the undersigned New Perspectives clinician for the purpose of review or audits or for necessary insurance purposes to authorized representatives of my insurance.*

Insurance payment of benefits: *I authorize payment of benefits to be made on my behalf directly to New Perspectives for services.*

Financial agreement: *I understand that I am responsible for all Fees, regardless of insurance coverage.*

****COPAYS ARE DUE AT TIME OF APPOINTMENT, OR APPOINTMENT WILL BE RESCHEDULED*

_____ _____

Patient's Signature Date

_____ _____

Signature of Parent or Guardian (if required) Date

Medical History

Patient Name: _____Date: _____

Date of birth: _____ Primary Care Physician: _____

Chief Complaint/Reason for being seen:_____

_____

Allergies: _____

List all Current Prescription medications and dosage. If none, write “none”.

Medication Daily dosage Prescribed by

_____

_____

_____

_____

_____

_____

List all current over-the-counter medications or supplements:

_____

_____

_____

Personal and Family Medical History:

Please Check any that pertain:

	You	Family
Anemia		
Arthritis		
Asthma/Respiratory		
Cancer		
Chronic fatigue		
Chronic pain		
Diabetes		
Epilepsy or seizures		
Fibromyalgia		
Head trauma		
Headaches/migraines		
Heart disease		
Hypertension		
Stroke		

Outpatient treatment ( ) Yes ( ) No
Reason Dates Hospitalized Where

_____
_____
_____

Past Psychiatric medications:

_____
_____
_____

Substance use: Have you ever been treated for alcohol and/or drug abuse? ( ) Yes ( ) No
If yes, for which substances: _____
If yes, where were you treated and when? _____

Do you drink alcohol? ( ) Yes ( ) No
Frequency of use: _____ Amount of use: _____

Tobacco history: Have you ever used cigarettes, pipe, cigars, or chewing tobacco: if yes to either list how many years of use and the amount of use
( ) currently_____
( ) Past use _____

Please list any other information you feel would be pertinent or helpful for your provider regarding your medical/psychiatric history:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

7829 E Rockhill Suite 305
Wichita, KS 67206

121 College St
Winfield, KS. 67156

Phone: 316.869.2888
Fax: 316.425.5550

Phone 620.402.6939
Fax: 620.402.6359

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and understand the laws of HIPAA and New Perspectives' Privacy practices. I give permission for New perspectives to leave a message on my voicemail or with a third person who may answer my telephone concerning a scheduled appointment.

Circle one: YES NO

If Yes, please circle the appropriate: Home phone Cell phone Work

Alternate number to be called: _____

We often are contacted by a patient's family members or friends and asked to report on the patient's condition, or to provide information concerning charges and payment for services provided. If you are present at the time a family member requests such information, we may ask you whether you want us to share information with your family member or friend. If you are not present at the time such a request is made by a family member (e.g. over the telephone), we will follow your prior instructions in determining whether we should share any information. If you have not provided any such instruction, we will contact you before providing any specific response to and inquiry from a family member or friend.

Please Check only *ONE*:

____ Do not share my information with family members except in emergency situations

____Share information with my spouse only, unless I specifically direct you not to share certain information with my spouse.

____Share information with the following family members or friends upon their request unless I specifically direct you not to share certain information.

Authorized family and Friends include:

Name	**Relation**
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____
Signature of Patient or Guardian Date

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INFORMED CONSENT

The therapist and staff are committed to providing the best possible care. It is important to our professional relationship that you understand our fee and payment policies. If you have any questions about our fees, our policies, or your responsibilities, please ask. After reviewing the following information please sign with today's date and return this form to us.

All patients must complete the "Patient Information Form" before seeing the counselor. You are responsible for notifying our office of any patient information changes (i.e. address, name change, insurance change, etc.). In addition, you will receive the HIPAA Notice Form for the state of Kansas informing you of the HIPAA rules and regulations regarding your Protected Health Information. Please read this information and inform the staff of any questions you may have.

INSURANCE

We will file your insurance claims. We will not become involved in disputes between you and your insurance carrier. This includes, but is not limited to, deductible, co-payments, non-covered charges, and "usual and customary" charges. We will supply factual information as necessary. We reserve the right to not bill your secondary insurance. We cannot bill third party insurance. **You are responsible for the timely payment of your account.** If you become involved in legal proceedings that require a therapist's participation, you will be expected to pay for all professional time, including preparation and transportation costs, even if the therapist is called to testify by another party. Because of the difficulty of legal involvement, New Perspectives charges slightly more per hour for preparation and attendance at any legal proceedings.

FLEXIBLE SPENDING ACCOUNTS

We will do our best to assist you in obtaining reimbursement for your flexible spending account. However, in the event that our receipt for services is not sufficient we will not become involved in dispute between you and your account manager. At your request, you will receive a receipt for services. In addition, we will provide you with a printed copy of your applied payments **once monthly** per your request free of charge. **Any additional printouts will be subject to a $3.00 administrative fee.**

AUTHORIZATION:

If an authorization is required for your insurance, it is your responsibility to obtain this authorization from their primary insurance company prior to any appointments. Failure to obtain an authorization may result in reduction of benefits.

RECORDS:

Records to be sent to a new provider will be forwarded after a release of records consent has been signed. HIPAA regulations allow the client to request an examination and/or receive a copy

of their clinical record. In the instance that this is requested a release must be filled out and the therapist will then review your records. In most cases this request will be granted but in special circumstances it may be denied such as when disclosure would physically endanger you and/or others or make reference to another person that the therapist believes is likely to cause substantial harm. At your request, the details of the request and denial process can be discussed with you.

MINORS:
The parent(s) or guardian(s) is responsible for full payment and will receive the billing statement. Client under the age of 18 who are emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. Because privacy is often crucial to successful progress, particularly with teenagers, we may request that the parents give up access to their child's records. If they agree, we will provide the parents with a summary of the child's treatment when it is completed unless the child is in danger or is a danger to someone else. In this case, we will notify the parents of the situation immediately. A signed release to treat may be required for unaccompanied minors.

CO-PAYS/CO-INSURANCE:
Co-payments and/or co-insurance are due at the time you check in at the front desk **PRIOR** to being seen by the therapist

UN-PAID BALANCES:
We ask that full payment be made at the time of service unless prior arrangements have been made through the business office. Any overdue balances may be considered for further collection action. We accept cash, checks, or any of the following credit cards for payment: VISA, MASTERCARD, and DISCOVER.

RETURNED CHECKS:
The charge for returned check is $30.00 payable in case or money order. This will be applied to your account in addition to the sufficient fund amount. You may be placed on a "cash only" basis following any returned check.

CANCELLED/MISSED APPINTMENTS:
The therapists in this office have a limited number of openings for scheduled appointments each week. Without 24-hour notice, they are often unable to use the time for another appointment. Because of this, a charge will be applied to your account in the event that you do not cancel your appointment within 24-hours.

I UNDERSTAND I WILL BE CHARGED FOR ANY MISSED APPOINTMENT OR LATE CANCELATION WITHOUT A 24-HOUR PRIOR NOTICE.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND SERVES AS AN ACKNOWLEDGMEENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____
PATIENT NAME (please print)

_____ _____
RESPONSIBLE PARTY (signature) DATE

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MEDICATION AGREEMENT

The purpose of this agreement is to prevent misunderstanding about certain medications you may be taking for your Psych Meds. This is to help both you and your prescriber comply with the law regarding controlled pharmaceuticals.

Initial:

_____ I understand this agreement is essential to the trust and confidence necessary in the doctor/patient relationship and that my prescriber will render treatment based on the agreement.
_____ I understand that if I break this agreement, my prescriber will stop prescribing these medications.
_____ I will communicate fully with my prescriber about the character and intensity of my symptoms , the effect of the medication on my daily life, and how well the medication is helping to relieve symptoms.
_____ I will not use illicit drugs including cocaine, methamphetamine, marijuana, etc.
_____ I will not share, sell or trade my medications with anyone.
_____I will not attempt to obtain any controlled medication, including opiates, controlled stimulant, anti-anxiety, or any other medications within the same classification from another doctor.
_____ I will safeguard my medications from loss or theft. *Lost or stolen medications will not be replaced.*
_____ I agree that refills on my prescriptions for such controlled medications will only be made at the time of an office visit or during regular office hours. No refills will be available during evenings or weekends.
_____ I authorize the prescriber and my pharmacy to fully cooperate with any city, state or federal law enforcement agency. Including this state's Board of Pharmacy, in the investigation of any possible misuse, sale or other diversion of my medications.
_____ I agree that I will submit to a blood or urine test if requested by my prescriber to determine compliance with my program of my medication.
_____ I agree that I will use my medication at a rate no greater than prescribed. Requests for early refills will not be acknowledged. The use of my medication at a greater rate will result in my being without medication and termination of treatment from this clinic.

PHARMACY OF CHOICE:

I agree to use_____ Pharmacy.
Located at_____.
Telephone Number_____ for filling prescriptions for all Psych medication. I agree to follow these guidelines that have been fully explained to me. All of my questions and concerns regarding treatment have been adequately answered.

This agreement is entered on the _____day of _____, _____.
(day) *(month)* *(year)*
Patient Name (print): _____.
Patient/ Guardian Signature: _____.

Prescribing Physicians Signature: _____.

EFFECTIVE OCTOBER 1ST, 2016 New Perspectives providers are committed to following the conditions of this agreement. We strongly recommend you take this agreement seriously and abide by these conditions. IF YOU VIOLATE THIS AGREEMENT WE WILL NO LONGER PRESCRIBE YOUR MEDICATIONS AND YOU WILL FACE TERMINATION FROM THIS CLINIC.