Dr. Luis Hines and Associates, PA

2828 SW 22nd Street, Suite 460, Coral Gables, Florida 33145
Telephone: (305) 642-5255 Fax: (305) 642-8850

Name: ________________________ Phone#: ______________________ Date: _____________

PRIMARY INSURANCE

Person Responsible for Account____
(Last Name) (First Name) (Middle Initial)

Relation to Patient________________Birthdate_______________SS#_____________________________

Address (if different from patient's)_________________________Phone (___)____________________________

City____State___________Zip_________________________

Person Responsible employed by_________________________Occupation______________________________

Business Address______________________________Business phone (___)____________________________

Insurance Company____

Contract #__________________________Group#_________________Subscriber#________________________

Names of other dependents covered under this plan____

SECONDARY INSURANCE

Is patient covered by additional insurance? Yes No___

Subscriber Name_____________________________Birthdate____________Relation to Patient________________

Address (*if different from patient's*)____ Phone (____) _____________

City____State___________Zip _____________

Person Responsible employed by____Occupation ________________

Business Address____Business phone (____) _______________

Insurance Company____

Contract #__________________________________Group#_____________Subscriber#__________________

Names of other dependents covered under this plan____

I certify that I, and/or my dependent(s), have insurance coverage with____________________and assign directly to the Psychologist/Psychiatrist/LMHC/ARNP, all the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by Insurance. I authorize the use of my signature on all Insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for obtaining payment for services and determining Insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

____ ___________________________
Signature of Patient, Parent, Guardian or Personal Representative **Date**

____ ___________________________
Please print name of Patient, Parent, Guardian or Personal Representative **Relationship to Patient**

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Authorization of Disclosure

Protected Health Information to Primary Care Physician

Communication between Behavioral Health Providers and your Primary Care Physician (PCP) is important to ensure that you receive comprehensive and quality health care. This form will allow your Behavioral Health Provider to share Protected Health Information (PHI) with your Primary Care Physician (PCP). This information will not be released without your signature authorization. This PHI may include diagnosis, treatment plan, progress, and medication if necessary.

______________________________ ______________________ ______________________
Member Name *Member Identification Number-optional* **Identification Number** **Date of Birth** (MM/DD/YYYY)

Authorize:_______________________________to release protected health information related to my evaluation and treatment to:

PCP Name:_______________________________________PCP Phone: ____________________

PCP Address: ____________________ ____________________ ______________ ______________
(Street) (City) (State) (Zip Code)

Patient Right

You can end this authorization (permission to use or disclose information) any time by contacting the following:

If you make a request to end this authorization, it will not include information that has already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.

- ❖ You are not required to sign this form as a condition of treatments, payment, enrollment, or eligibility for benefits.
- ❖ Information that is disclosed as a result of this Authorization Form may be re-disclosed by the recipient and no longer protected by law.
- ❖ You have a right to a copy of this signed authorization. Please keep a copy for your records.
- ❖ You do not have to agree to this request to use or disclose your information.

Patient Authorization

I, the undersigned understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire on the date specified below or within one (l) year or less from the date of signature. I have read and understand the above information and give my authorization to:

Please Check One

______To release any applicable mental health / substance abuse information to my primary care physician.
______To release only medication information to my primary care physician.
______To release the date of my first visit following my hospitalization from______to_______to my Primary Care Physician.
______**I DO NOT** give my authorization to release any information to my primary care physician.

______________________ ______________ ______________________ ________
Patient Signature Date (Expiration) Signature of Patient's Authorized Representative) (Date)

CONFIDENTIALITY NOTICE: This message is protected under the Federal regulations governing Confidentiality of Mental Health Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Pts. 160 & 164 and cannot be disclosed without written consent unless otherwise provided for in the regulations. The Federal rules prohibit any further disclosure of this information unless a written consent is obtained from the person to whom it pertains. The Federal rules restrict any use of this information to criminally investigate or prosecute any Mental Health patient. If you are not the intended recipient, please contact the sender by reply e-mail or the phone numbers provided and destroy all copies of the original message.

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Treatment Consent Form

(Please read carefully and initial or sign where necessary)

This Informed Consent form is designed to explain the policies and procedures for an evaluation or psychological services at Luis Hines and Associates, PA. There is a separate consent form for treatment / counseling. Please thoroughly review this document as it contains information that is very important for you to know.

Services Offered:

Pharmacotherapy

Psychiatric medications can be used in conjunction with psychotherapy to treat many conditions. It is important to find the best combination of medications and therapy for each individual case. Your provider can provide an integrated approach as they are trained to administer both psychiatric medications and psychotherapy. Additionally, since all medications have the potential for side effects, your provider will always discuss the risk, benefits, side effects, government warnings, and alternative treatments (which always includes not using medication) with you.

Consent for Psychotropic Medication

I understand that as part of my treatment, I may be prescribed psychotropic medications to help manage symptoms related to my mental health. My provider has explained the dosage, frequency, risks, benefits, and potential side effects of these medications, and I have had the opportunity to ask questions. I understand that although the provider has explained to me the most common side effects of treatment there may be other side effects, and that I should promptly inform the provider or a member of his/her staff of any unexpected changes in my condition. I also understand that although the provider believes that this medication will help, there is no guarantee of results to be expected. I consent to the use of psychotropic medications as part of my treatment plan.

Consent for Treatment by an Advanced Registered Nurse Practitioner (ARNP)

I understand that part of my care may involve treatment by an Advanced Registered Nurse Practitioner (ARNP) working under the supervision of Dr. David Kramer, MD, the Medical Director. I consent to treatment provided by the ARNP, recognizing that the ARNP will consult with Dr. Kramer to ensure the quality of my care.

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Psychotherapy

Often called talk therapy, this form of treatment can be helpful to both individuals and families. Benefits can include significant stress reduction, improved relationships, resolution of specific problems, and improved self-insight. However, therapy is not guaranteed to work for everybody and can be a large financial commitment as well as requiring a significant amount of time and energy. Moreover, psychotherapy may also require exploring unpleasant aspects of your life and can, at times, lead to feelings of distress (i.e., guilt, anxiety, frustration, etc.). These unpleasant aspects are generallytemporary but are extremely important to discuss when present. Always remember that anything can be discussed in therapy. Thus, it is important to let our providers know if you feel that your goals are not being met. These issues can be addressed in session.

Psychological Testing Services

The evaluation process takes place in four primary stages:

1) Diagnostic interview to obtain a history, review concerns, discuss the reason for the evaluation, determine what testing needs to be done, and review informed consent and evaluation procedures.
2) Testing may take place in one or two sessions, based on the patient's needs as determined during the diagnostic interview.
3) Scoring, interpretation and report writing by the psychologist.
4) Phone call or appointment to provide interpretation about testing results, diagnostic impressions and treatment recommendations about 4-6 weeks after completion of the testing process.

In addition to the stages of the evaluation described above, other services are sometimes needed. It is often helpful for the evaluator to speak with other professionals who have worked or are working with the patient. This includes therapists, physicians, counselors, teachers, speech or occupational therapists. You will be asked to sign additional written consents if this is necessary.

A comprehensive written report will be generated and copies will be provided to you as part of the evaluation costs. The results of the evaluation may not answer all questions about the patient's situation. Thus, other referrals may be made to other service providers.

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Treatment Policy

For Psychological Testing Services Only

Luis Hines and Associates P.A. adheres to a set of guidelines as mandated by insurance carriers, which includes Eight (8) psychotherapy visits by either Luis Hines and Associates clinician or an outside clinician/facility. If treatment is obtained by an external source, a referral and all pertinent medical records and supporting documentation must be presented to continue treatment. Self-pay does not apply.

Benefits and Risks of Evaluation

The primary benefits of an evaluation include diagnostic clarification, appropriate treatment recommendations to handle challenges and maximize strengths, a written report to facilitate services in the community or at school and insight into the nature of the patient's strengths and weaknesses. Although most individuals have a positive experience during the evaluation process, there are some risks. The person being evaluated may experience discomfort (frustration, anxiety, embarrassment, etc.). In addition, it is possible that the evaluation will not answer all of your questions and further evaluation will be needed. While the assessment and treatment recommendations are based on best practices, you or others may not agree with the conclusions based on the professional's judgment. It is your decision whether to follow the recommendations.

Professional Records

Mental health records are standard practice in psychiatry and protected by both law and professional standards. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging for our providers to provide you with the full records, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

Discharge of Patients for Noncompliance

Along with our cancellations and no-show fee policy, if a client has failed to show up to their last five (5) scheduled appointments in the last six (6) months they will fall under noncompliance. Once deemed noncompliant the client will be given a formal discharge letter informing them they are discharged as a patient at our practice. **Five (5) cancellations/ no-shows = Discharge for noncompliance.**

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Confidentiality

Confidentiality is a cornerstone of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage. Several exceptions to confidentiality do exist that actually require disclosure by law: **(1) Danger to Self** - if there is threat to harm yourself, I am required to seek hospitalization for the client, or to contact family members or others who can help provide protection; **(2) Danger to Others** - if there is threat of serious bodily harm to others, I am required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization; **(3) Grave Disability** - if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, I may have to disclose information in order to access services to provide for your basic needs; **(4) Suspicion of Child, Elder, or Dependent Abuse** - if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, I must file a report with the appropriate state agency; **(5) Certain Judicial Proceedings** - if you are involved in judicial proceedings, you have the right to prevent me from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require my testimony through a subpoena. Although these situations can be rare, our providers will make every effort to discuss the proceedings accordingly. Our providers also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

Contacting our Providers

Our providers attempt to be accessible for all urgent issues. If they are not immediately available by office telephone, please leave a voice message and we will return your call as soon as possible. Calls are generally returned within one business day.

Please be thoughtful when calling Providers (Psychiatrist/ARNP) after normal business hours. If your call is an emergency, please contact 911 immediately instead of calling the office. Emergency psychiatric services are provided by all hospitals through their emergency rooms and do not require appointments. When our providers are unavailable for extended periods (i.e., vacation, conferences, observance of National Holidays, etc.), a trusted colleague provides telephone coverage and contact information will be provided on our office voicemail. Also, note that an email should never be used for urgent or emergency issues. This is not a confidential means of communication and our providers cannot ensure that email messages will be received or responded to in a timely manner.

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Treatment Consent

Your signature below indicates that you have read the Treatment Consent Form and you agree to abide by its terms during our professional relationship. I understand that a range of mental health professionals, some of whom are in training, provides psychotherapy services. All professionals-in-training are supervised by a licensed mental health professional.

Name of Patient: ____
(Print)

Name of Legal Guardian: ____
(Only if patient is under 18 or a dependent adult) **(Print)**

Signature of Patient or Legal Guardian________________________________Date: __________

NOTICE OF PRIVACY PRACTICES

"We Care About Your Privacy"

Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

- ❖ I acknowledge that I have read the informed Consent for Assessment & Treatment.
- ❖ I have received and read the Notice of Privacy Practices Form.
- ❖ I have received and read the Patient's Bill of Rights and Responsibilities Notice.

Signature of Patient or Representative:______________________________Date: _____________

Print Name:____________________________Relationship to Patient: ______________________

Interpreter (if applicable): ____

____ Initials

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NO SHOW BALANCE CANCELLATION POLICY
CREDIT CARD AUTHORIZATION FORM

Copay/Outstanding Balance: By signing this form, you give us permission to debit your account for the amount to cover outstanding balance or copayments. This is permission is for multiple transactions and provide authorization for any additional unrelated debits or credits to your account.

No-Show/Cancellation Fee: Due to high patient demand and limited availability of appointment, we have a No Show Fee that requires cancellation with at least **24-hour notice**. We do not double book appointments; your appointment is reserved exclusively for you. When a patient misses a scheduled appointment without 24-hour notice Luis Hines and Associates, PA charges a fee.

Any appointment that is a no-show or a last-minute late cancellation will be subject to a **$60.00-$80.00** no-show fee or cancellation fee. This fee will be billed directly to you, not your insurance company.

By signing below, I acknowledge that I have read and understand this policy. I authorize Luis Hines & Associates to charge the amount listed above the credit card provided herein. I agree to pay for this charge in accordance with this agreement.

Check One:
Amount to Charge: Therapist $60.00 (USD) Psychiatrist $80.00 (USD)

Credit Card Type: ___Visa MasterCard _ Discover _AmEx

Credit Card Number: ______________________________________

Expiration Date:________________CVV Code: _______________

Name On Card: ____

Billing Address: ____

Patient Name:

____________________________ ____________________________
Print Date

Card Holder Name:

____________________________ ____________________________
Print Date

____________________________ ____________________________
Signature of Cardholder Date

Office Guidelines

- No cellphones or loud talking in the waiting area. You will be asked to reschedule.
- Bring your ID & current insurance to every visit. Notify our office of any changes in your insurance coverage, address, phone, etc. If your insurance cannot be verified, you must pay at the time of your visit. You will not be seen without providing your current insurance card.
- Co-payments are collected prior to your service. Service charges will be added if we bill you for a co-payment.
- Any child under the age of 18 must be accompanied by his/her legal guardian at the time of service.
- A fee will be incurred in the case of a missed or cancellation of an appointment without a 24 hour notice.
- Failure to keep scheduled appointments or adhere to an agreed treatment plan will be subject to patient discharge after 3 missed appointments.
- If you arrive more than 15 minutes after the time of your scheduled appointment you session will be cut short, and all on-time patients will be seen ahead of you.
- Walk-in visits are not guaranteed same day service.
- Fit-in visits are brief and focused thus it is not a guaranteed appointment.
- All psychiatric patients under medication management MUST be treated by a therapist at least monthly (in-office or out of office therapy).
- Appointments are required for medication refill requests. Please keep in mind that our schedules are full and do not wait to run out of medicine to schedule your appointment.
- There is a fee of $1 per page for copying medical records; free of charge if we need to submit to a PCP or health care office.
- All forms are subject to a fee (payment must be received prior to completion);
    - ESA Letter: $205
    - Airline ESA $100
    - FMLA/Disability 3 pages: $100; over 3 pages: $150
    - Letters to Attorney: $80 for the first page and $25 for every extra page.
    - Return to work/school, Jury Duty Excusal, PCP Letter – free of charge.
- Only clients are allowed in the waiting area; or one guardian with a minor.
- Do NOT write/lay/place feet on furniture or tables!
- For complaints or concerns please contact our Human Resources Dept. (305)642-5255 ext. 415 orManager (305)642-5255 ext. 403.

_____ Initials   Date: ______________