**New Patient Information**

Please fill this form out and submit or email before making an appointment

| Name (First, Last) | | |  |  |  |  | M.I. | | Birth Date | | | Today's Date |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Street Address | | |  |  |  |  |  | City |  |  |  | State/Zip |
|  |  |  | |  |  |  |  |  |  |  |  |  |
| Insurance provider: | | | | #: |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  | |  |
| Home Phone: | | |  |  | Cell: |  |  |  |  | Email: | |  |
|  |  |  |  | |  |  |  |  |  |  |  |  |
| Which preferred: | | | Text OK? Yes | | No |  |  |  |  |  |  |  |
| If needed, may we leave a message on your answering machine? Yes □ No | | | | | | | | | | | |  |
|  |  |  | | | |  |  |  |  |  |  |  |
| Primary Care Provider Name, Phone and Address | | | | | |  |  |  |  |  |  |  |
|  |  |  | |  |  |  |  |  |  |  |  |  |
| Pharmacy Name, Phone and Street/City | | | |  |  |  |  |  |  |  |  |  |
|  |  |  | | |  |  |  |  |  |  |  |  |
| Where else have you received mental health treatment | | | | |  |  |  |  |  |  |  |  |
|  |  |  | | | | | | |  |  |  |  |
| Allergies: |  |  | | | | | | |  |  |  |  |
| Medications (  Current and  Past |  |  | | | | | | |  |  |  |  |
| In case of an emergency, is there someone we can contact (list | | | | | | | | |  |  |  |  |
| below): Can we share with them information about your mental | | | | | | | | |  |  |  |  |
| health condition? Please mark Yes or No next to the | | | | | | name | | |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Yes | No | Name |  |  |  |  |  | Phone |  |  |  | Relationship |
|  |  |  |  |  |  |  |  |  |  |  |  |  |
| Yes | No | Name |  |  |  |  |  | Phone |  |  |  | Relationship |
|  |  |  |  |  |  |  |  |  |  |  |  |  |

**Treatment Consent and Acknowledgement**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Effective care provision requires the following policies to enable:

1. **Financial Policy: Purple Health Wellness** will bill for all appointments unless initially billing insurance. In the initial process of credentialing **Purple Health Wellness** will charge all appointments unless able to bill insurance retroactively after credentialing.
2. **Payment Policy:** All payments are due at time of services. All payments can be done online with a debit or credit card. Each client will be asked to keep amajor credit card on file. Payment for appointments will be automatically pulled from the account following the appointment, and invoice will be emailed. If a client is unable to provide a credit/debit card, alternatives may be approved on a case by case basis. After two notices or two months (whichever is sooner) without payment or arrangement between client and provider, outstanding balances will be sent to collections with additional collections fee added. Appointments cannot be made if prior appointments are not paid, or payment arrangements are late. Automatic withdrawal from a credit card will be the default method of payment unless otherwise discussed between client and provider. Copays are due at time of appointment.

**3**) **Appointment /Cancellation Policy: All appointments should be kept as scheduled to ensure consistency in the treatment process. A $50 fee will be charged for cancellations without a 24-hour notice or non-appearance for a scheduled visit. As a general rule, for medication management patients must be seen at minimum every 3 months after medications are stabilized.**

**4) Medication Policy:** Medication renewal will occur during the medication follow -up visit with the prescribingprovider. No medication will be prescribed over the phone routinely. **At this time, Purple Health Wellness does not prescribe controlled medication.** The provider may not initiate medication or ask for sobriety prior to initiating medication if substance abuse is evident.

**Purple Health Wellness reserves the right to drug test patients prior to or during medication management. Adequately screening for substances that may interact dangerously like illicit and prescribed drugs is essential to prevent severe injury to our patients.**

**5**) **Refill requests:** Please do not call our office for medication refills- call your pharmacy first, because most likelythe pharmacy already has refills available on file. If refill is needed you must have your pharmacy fax us a request at least 7 days in advance

**6) Phone Policy:** If you need to contact Purple Health Wellness between sessions, please call our main number or send us a message through the patient portal. We are often not immediately available; however, we will attempt to return your call or message within 24 hours. Please note that Face-to-face video visits are highly preferable to phone visits. However, in the event that you are out of town (dependent on current location), sick or need additional support, brief phone sessions are available. If a true emergency situation arises, please call 911 or go to your local emergency room.

**7) Letters and Forms:** Any letters or forms which require more than 5 minutes of time to complete will be charged a fee of $50 to complete.

**8) TERMINATION:**

We can terminate treatment with you at any time. We will not terminate the medical relationship with you without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason, we will provide you with a list of qualified providers to continue your care. You may also choose someone on your own or from another referral source. Should you fail to not show up for your follow up appointments, not obtain lab work in a timely fashion or are non-compliant with treatment, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider the professional relationship discontinued.

**9) ELECTRONIC COMMUNICATION:**

We cannot ensure the confidentiality of any form of communication through electronic media, including, but not limited to, text messages, telephone communication, the Internet, facsimile machines, and e-mail. Telemedicine is broadly defined as the use of information technology to deliver medical services and information between two parties that are at different locations. The above electronic means of communication are considered telemedicine. Utilizing telemedicine services through (Purple Health Wellness) is voluntary in nature and you need to understand:

1. You have the right to withhold or withdraw your consent for telemedicine services at any time. If this occurs, you need to understand that we cannot provide care for you any longer as (Purple Health Wellness) strictly a telemedicine practice.
2. We will protect your protected health information in the same fashion as a brick and mortar practice. You need to understand though that data breaches can happen, and we cannot assure your information is 100% protected.
3. We will not use your protected health information for research purposes unless you give us consent to do so.
4. There are potential benefits, risks and subsequent consequences of telemedicine. Potential benefits include, but are not limited to improved access to care, reducing costs, improving the quality of visits, and reduction of travel time associated with medical visits. The medical provider will make assessments, diagnoses, and treatment plans based off all the visual and auditory information provided during the video conference. You must understand that this is limited and posts potential risks including, but not limited to the provider’s inability to make complete diagnostic assessments that might require a physical exam and to see the patient in person. During an in-person encounter, a medical provider has the ability to see the entire patient including but not limited to their gait, smell, general appearance, and demeanor. Potential consequences thus include the provider not being aware of clinically significant information that you may not recognize as significant to present verbally to the provider.

In signing below, you agree to begin treatment with the policies above and acknowledge receipt of the Privacy Notice.

Patient Signature Date Parent/Guardian Date



*If not signed by patient, please indicate relationship to patient (e.g., spouse)*



**Patient's Rights**

1. The Patient has the right to considerate and respectful care and treatment, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs
2. The Patient has the right to have their care and treatment information kept private and have the opportunity to have their records released only with their written permission, except required by law.
3. Patients have a right to make informed choices regarding their medications, behavioral health services, and their providers.
4. The Patient has a right to expect reasonable continuity of care.
5. The Patient has the right to examine and receive an explanation of costs for treatment as applicable.
6. The Patient has the right to know what relationship (Your LLC) has with other health care providers and facilities in regard to their health care.
7. The Patient has the right to inquire as to their provider's degree, licensure, and training.
8. The Patient has the right to inquire as to the role of the providers on the treatment team in the treatment process.
9. The Patient has the right to an explanation of their condition and the treatment options.
10. The Patient has the right to expect that (Your LLC) will make reasonable effort in providing the identified services of the treatment plan.
11. The Patient has the right to be informed if (Your LLC) is engaging in research about behavioral health care and have the right to refuse participation in that research.
12. The Patient has the right to register complaints to their behavioral health care professional and/or an administrator.

**Patient's Responsibilities**

1. The Patient has the Responsibility to treat those providing care with dignity and respect.
2. The Patient has the Responsibility to ask questions regarding the diagnosis, treatment, medications, or any instructions.
3. The Patient has the Responsibility to follow instructions concerning medications, follow-up visits, and other essential components of their treatment and to notify their behavioral health care provider if the instructions cannot be followed or problems develop.
4. The Patient has the Responsibility to assist (Your LLC) in obtaining approvals for payments for treatment, referrals, and authorizations.
5. The Patient has the Responsibility to provide as much information as is possible to their provider to assist in the assessment and rendering of services.

Patient's Signature Date Parent/ Guardian Signature Date



*If not signed by patient, please indicate relationship to patient (e.g., spouse)*

**Acknowledgement of Receipt of Privacy Notice**

I have been presented with a copy of (Your LLC)’s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice.

I hereby authorize (Your LLC) to release to my insurance company or its representative, if requested, any/all information requested to include my diagnosis and records of my mental health treatment by this practice. I also authorize (Your LLC) to request health information including therapy notes from previous healthcare providers as identified by the clients. Furthermore, I hereby give consent to (Your LLC) to render mental health services deemed necessary for myself and/or minor child as designated in the treatment plan.

Patient's Signature Date Parent/ Guardian Signature Date



*If not signed by patient, please indicate relationship to patient (e.g., spouse)*

