carroll COUNSELING center

YEARLY PATIENT UPDATE FORM

Please Print Clearly

Form is valid from January 1 – December 31

PATIENT DEMOGRAPHICS

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____ Date of Birth: _____ Sex: _____ Gender Identity: _____

SSN: _____ Main Phone #: _____ Email: _____

Street Address: _____Unit / Apt # (if applicable) _____

City: _____ State: _____ Zip Code: _____ Marital Status: _____

Would you like to receive appointment reminders?**

Correspondence sent via email: opt in ☐ opt out ☐ Email: _____

Appointment Reminders by text: opt in ☐ opt out ☐ Cell #: _____

**Please note – the office can only use ONE email and/or ONE cell phone number to receive the automatic reminders for upcoming scheduled appointments – The office staff does not provide physical reminders as we utilize the automated system to better assist patients.

INSURANCE INFORMATION – Please Submit a Copy of the front and back of your card/s

Primary Insurance: _____ Claims Address: _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS#_____ Employer: _____

Policy #: _____ Group # (if applicable) _____

Secondary Insurance (if applicable): _____

Subscriber's Name: _____ Relationship to Patient: _____

Date of Birth: _____ SS# _____ Employer: _____

Policy #: _____ Group # (if applicable) _____

SELF PAY / NO INSRUANCE (Only patients without insurance)

☐ I do not have health Insurance / Do not wish to have my health insurance billed. – See self-pay waiver

carroll COUNSELING center

YEARLY PATIENT UPDATE FORM

Please Print Clearly

Form is valid from January 1 – December 31

OFFICE POLICIES AND SIGNED CONSENT OF PRIVACY PRACTICES

- **General Office Policies:**

I understand that Carroll Counseling Center is a Fee-For-Service office and all copays, deductibles, and coinsurance payments that are not covered by my insurance are due in full at the time of service. The accepted payment methods are American Express, Visa, Mastercard, Discover, Personal Checks and Money Orders. To continue my care with Carroll Counseling Center, I understand that I am responsible for keeping my account current and up to date with balances owed. *All past due amounts must be paid in full* prior to scheduling future appointments or submitting refill requests on medications. The office will charge a **$28.00 fee** for any **returned check/s**. Past due accounts are subject to a **3% late interest fee** as well as a no reschedule policy until the balance is paid in full. The office requires **24HOUR notice** to break any appointment/s, this policy is strictly enforced and will be subject to the following fees that are not covered by the insurance/s – Please note that Contracted providers can set a fee outside of the rates listed below. If your provider has a different fee exceeding the amounts below, they are to notify the patients at the first (Initial) appointment: The standard fees are as follows:

- **Medication Management Patients: $75.00 late cancelation fee or $75.00 no-call / no-show fee**
- **Therapy Patients: $75.00 late cancelation fee or $75.00 no-call / no-show fee**
- **Testing patients: $75.00 per hour late cancelation fee or $75.00 per hour no-call / no-show fee**

The office does provide 24hour phone coverage which will allow you to leave a message to cancel any appointment. Patients who are running more than 10 minutes late are subject to have the appointment canceled and rescheduled by the provider to the next available opening to reduce the run over time for other patients on the schedule. I declare I have listed all medical health insurance plans from which I may allow Carroll Counseling Center to bill on my behalf. I agree that the information supplied on these forms are accurate and up to date to the best of my knowledge. Any future changes in the above information, especially those that may affect the processing of my insurance claims, shall be updated with Carroll Counseling Center in a timely manner before any service have been rendered. **Any claim/s that comes back from my insurance company that is not covered for any reason/s will be made the patients responsibility**.

X_____ (Please Initial as acknowledgement to the above General Office Policies)

- **Testing Patients (Please skip if you are not scheduled for testing):**

I agree to allow my testing provider with Carroll Counseling Center to discuss treatment with my current physician/s listed above to better assess the needs of my Psychological / Neurological Testing. Depending upon my providers schedule, I understand that it could take roughly 3-5months from start to finish to complete my Intake, Testing and Feedback (Results Session) – In total I understand there may be THREE - FOUR different appointments scheduled. The first appointment will be the Initial Intake – The Second and possible Third appointment will be testing (this could range from 2-3 hours each) – My last appointment will be when I meet with the provider to discuss my results and will receive my completed report. All applicable Copays, Co-Insurance and/or Deductibles are due at each appointment.

X_____ (Please Initial as acknowledgement to the above Testing Policies)

- **Medication Policies:**

I understand that all prescription refills may take up to 72 hours to be sent to my pharmacy from the time my provider receives the request. Refills will be made only during regular office hours – Monday through Friday, 9:00AM-5:00PM per the refill request line that is checked by the office Medical Assistants. Refills will not be provided overnight, on holidays or on weekends. I understand that I must call at least FIVE (5) business days ahead (Monday – Friday) to request a refill for all applicable medication/s. Only the medication/s stated in requests will be sent to the provider. I understand that I should check with my pharmacy to see if/when prescriptions are ready to be picked up before calling the office. I understand and acknowledge that my psychiatrist and/or Medical Assistants have the right to pull up my past and present controlled substance history on the CRISP database, contact pharmacies and / or call the patients primary contact number for any questions and / or concerns to better assist the prescribing of medications appropriately.

X_____ (Please Initial as acknowledgement to the above Medication Policies)

YEARLY PATIENT UPDATE FORM

Please Print Clearly

Form is valid from January 1 – December 31

- **Medical Records / Forms / Letters:**

  I understand that all disability forms and / or accommodations forms/letters are considered on a case-by-case basis by my provider. I understand that I must establish care for a minimum of three (3) to six (6) months prior to requesting any forms be completed. I understand that I am responsible for any fees associated with completing forms or letters from my provider. I understand that it is up to the provider's discretion to fill out requested forms or write any medical letters. I understand that medical record requests, form completion, and letter completion may take up to twenty-one (21) business days from the time of the request by the patient to the completion of release. **Forms and Letters are subject to a fee not covered by the insurance, ranging from $25 - $100+.**

  In accordance with Maryland Law, medical records requests are processed at the following rates:

  - The fee for copying records in electronic format is 75% of the per-page fee (see below) and may not exceed $80.00, as well as the actual cost of postage and handling. Health care providers may charge a preparation fee of $22.88 if the records are sent to a provider or a person other than the patient or the patient's personal representative. Federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient.

  - The fee for copying paper records is not to exceed 76 cents for each page of the medical record and the actual cost of postage and handling. Health care providers may charge a preparation fee of $22.88 if the records are sent to another provider or a person other than the patient or the patient's personal representative. Federal HIPAA regulations do not allow a charge for a preparation fee for records provided directly to the patient.

  X_____ (Please Initial as acknowledgement to the above Medical Records / Forms / Letters Policies)

- **Telehealth / Virtual Policies:**

  I understand that having a Telehealth / virtual appointment requires to have a current / up to date credit card on file that will be automatically ran after each confirmed appointment with my provider. A confirmed appointment will entail the provider notating that the appointment has been completed and is reading to be submitted for billing. Any projected amounts that are past due or exceed the visit projected amount will be communicated with the patient before the card on file is ran. I understand that it is my responsibility to update any outdated credit card information to prevent any delay in keeping my account up to date and current on patient responsibilities.

  X_____ (Please Initial as acknowledgement to the above Telehealth / Virtual Policies)

- **Notice of Privacy Practices (The use and disclosure of Health Information):**

  I understand that when Carroll Counseling Center examines, diagnoses, treats, or refers patients to internal / external providers, they will be collecting what the law calls Protected Health Information (PHI) about you. Carroll Counseling Center will use this information to decide and/or provide what treatment is best for the patient. Carroll Counseling Center may also share this information with others who provide treatment to the patient or need the information to arrange payment for treatment. This information can also be used for other business and/or government functions. By initialing below, you are agreeing to let Carroll Counseling Center use your information and send information to others for those purposes only. The attached **Notice of Privacy Practices** explains in more detail your rights and how we can use and share your information.

  X_____ (Please Initial as acknowledgement to the above Notice of Privacy Practices)
  *MUST BE INITIALED AGREEING TO THE PRIVACY PRACTICES TO RECEIVE TREATMENT AT THE CENTER.

I, as the patient / guardian, have read and understand all office policies above. I acknowledge that I have received a copy of the Notice of Privacy Practices and I consent to the policies and disclosure of my PHI for treatment.

Patient / Guardian Name: _____ Signature: _____

Date of Patient Consent: _____ Witness (Office Staff) Name: _____ Date: _____