Patient Initial Intake Form

Patient's Legal Name: _____ DOB: ___/____/_____

Patient's preferred name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____

Email address: _____

How did you hear about Helios Psychiatry? _____

Primary Insurance: _____

Name of Insurance Subscriber: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's address: _____

Secondary Insurance: _____

Name of Insurance Subscriber: _____

Subscriber's Date of Birth: _____/_____/_____

Subscriber's address: _____

Legal Guardian/Parents: _____

Emergency Contact: _____Relationship: _____

Emergency Contact Phone: _____

Pharmacy: _____

Pharmacy Phone#: _____

Pharmacy Cross Street: _____

Phone number for reminders: _____ Text: _____ or Call: _____

Adult patient or Legal Guardian Signature: Date:

_____ _____

Signing this document means that you agree that this information is true and accurate.

☐Please take pictures of the front and back of your ID & all insurance cards and email them to:

intake@heliospsych.com **This information must be submitted in order to be scheduled.**

Revised 2/10/2023

Helios Psychiatry and Counseling
Psychiatric Intake

Client Name:_____ **Date of Birth:**_____

Age:___ **Sex:**___ **Race:**_____

What brings you in for an assessment today? _____

Past Psychiatric History:

Have you ever been in a psychiatric hospital/ward? Yes No

How many times: _____

When was the first time? _____

When was the last time? _____

Have you ever attempted suicide? Yes No

How many times: _____

When was the last time? _____

How have you attempted? _____

Have you ever seen a psychiatrist before? Yes No

When was the last time? _____

Please provide the name and phone number _____

Do you currently have a therapist? Yes No

Please provide the name _____

And phone number _____

Your Medical History:

_____ **Heart Disease**
_____ **Diabetes**
_____ **Asthma/COPD**
_____ **Arthritis**
_____ **Fibromyalgia**
_____ **Stroke**
_____ **Hypertension / high blood pressure**
_____ **High cholesterol / lipids**
_____ **Hypothyroidism**
_____ **Cancer: Specify** _____

Other:

_____ _____
_____ _____
_____ _____

List any surgeries you have had:

_____ _____
_____ _____
_____ _____

Helios Psychiatry and Counseling
Psychiatric Intake

Who is your primary care doctor? _____

Allergies: No known drug allergies _____ **OR** _____

Please list all the medicines you take, including over the counter medications/supplements/vitamins

Medication	Dose	When do you take it?	What is it taken for?

Family History of PSYCHIATRIC problems:

Mother:

Father:

Brother:

Sister:

Grandmother:

Grandfather:

Anyone else:

Any Suicides in the family? Yes No

Helios Psychiatry and Counseling
Psychiatric Intake

Social History:

Marital Status: Married ____ Divorced ____ Widowed ____ Single ____

Please list the ages and sex of your children:

_____ _____

_____ _____

_____ _____

Who do you live with? _____

Which options below best describes your social situation?

Supportive social network Few friends No friends

Education level: High School Diploma Some College College Grad Post-Graduate Degree

Less than High School (Grade completed: ___) GED

Occupation:

Do you have any legal problems? Yes No

Substance Use History:

How frequently do you drink alcohol? _____

How much do you drink at a time? _____

Have you recently (within the last month) used any street drugs? Yes No

Which? _____

Do you have a history of abusing street drugs or alcohol? Yes No

Alcohol: Age first used: _____ **Age last used:** _____

Cocaine: Age first used: _____ **Age last used:** _____

Marijuana: Age first used: _____ **Age last used:** _____

Heroin: Age first used: _____ **Age last used:** _____

Amphetamines: Age first used: _____ **Age last used:** _____

Benzodiazepines: Age first used: _____ **Age last used:** _____

Other: _____ **Age first used:** _____ **Age last used:** _____

Do you or have you taken more of your prescription medications than you are/were supposed to? Yes No

Have you ever been in treatment for any substances? Yes No

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Total

GAD-7

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Mood Disorder Questionnaire

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?		
...you felt much more self-confident than usual?		
...you got much less sleep than usual and found you didn't really miss it?		
...you were much more talkative or spoke much faster than usual?		
...thoughts raced through your head or you couldn't slow your mind down?		
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
...you had much more energy than usual?		
...you were much more active or did many more things than usual?		
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
...you were much more interested in sex than usual?		
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
...spending money got you or your family into trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only. No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had bipolar disorder?		
5. Has a health professional ever told you that you have bipolar disorder		

Generic Name	Trade Name	When Tried	Reaction (Positive/Negative)
Acamprosate	Campral		
Buprenorphine	Subutex, Suboxone		
Disulfiram	Antabuse		
Methadone	Dolophine		
Naltrexone	ReVia, Vivitrol		
Varenicline	Chantix		
Amphetamine salts	Adderall		
Atomoxetine	Strattera		
Clonidine	Kapvay		
Dexmethylphenidate	Attenade, Focalin		
Dextroamphetamine	Dexedrine, Dextrostat		
Guanfacine	Intuniv		
Lisdexamfetamine	Vyvanse		
Methylphenidate	Concerta, Daytrana, Methylin, Ritalin		
Alprazolam	Xanax		
Buspirone	BuSpar		
Chlordiazepoxide	Librium		
Clonazepam	Klonopin		
Diazepam	Valium		
Hydroxyzine	Atarax, Vistaril		
Lorazepam	Ativan		
Oxazepam	Serax		
Pregabalin	Lyrica		
Carbamazepine	Carbatrol, Equetro, Tegretol		
Gabapentin	Neurontin		
Lamotrigine	Lamictal		
Lithium salts	Eskalith, Lithobid		
Oxcarbazepine	Trileptal		
Topiramate	Topamax		
Valproic Acid	Depakote, Depakene		
Amitriptyline	Elavil		
Bupropion	Wellbutrin		
Citalopram	Celexa		
Clomipramine	Anafranil		
Desipramine	Norpramin		
Desvenlafaxine	Pristiq		
Doxepin	Sinequan		
Duloxetine	Cymbalta		
Escitalopram	Lexapro		
Fluoxetine	Prozac		
Fluvoxamine	Luvox		
Imipramine	Antideprin		
Mirtazapine	Remeron		
Nortriptyline	Pamelor		
Olanzapine/fluoxetine	Symbyax		
Paroxetine	Paxil		
Phenelzine	Nardil		
Sertraline	Zoloft,		
Tranylcypromine	Parnate		
Trazodone	Desyrel		
Venlafaxine	Effexor, Efexor XR		
Vilazodone	Viibryd		
Vortioxetine	Trintellix		

Generic Name	Trade Name	When Tried	Reaction (Positive/Negative)
Amobarbital	Amytal Sodium		
Diphenhydramine	Benadryl		
Doxylamine	NyQuil, Unisom SleepTab		
Estazolam	ProSom		
Eszopiclone	Lunesta		
Flurazepam	Dalmane		
Melatonin	Circadin		
Midazolam			
Phenobarbital	Luminal		
Promethazine	Phenergan, Promethegan		
Ramelteon	Rozerem		
Sodium oxybate	Xyrem		
Temazepam	Restoril		
Triazolam	Halcion		
Zaleplon	Sonata		
Zolpidem	Ambien		
Zopiclone	Somnol		
Aripiprazole	Abilify		
Brexpiprazole	Rexulti		
Asenapine	Saphris		
Chlorpromazine	Thorazine		
Clozapine	Clozaril, Fazaclo		
lumateperone	Caplyta		
Fluphenazine	Prolixin		
Fluspirilen	Imap		
Haloperidol	Haldol		
Iloperidone	Fanapt		
Olanzapine	Zyprexa		
Paliperidone	Invega, Sustenna		
Perphenazine	Trilafon		
Lurasidone	Latuda		
Cariprazine	Vraylar		
Pimozide	Orap		
Quetiapine	Seroquel		
Risperidone	Risperdal, Consta		
Thioridazine	Melleril		
Thiothixene	Navane		
Trifluoperazine	Stelazine		
Ziprasidone	Geodon		
Pergolide	Permax		
Pramipexole	Mirapex		
Ropinirole	Requip		
Tramadol	Ultram		
Armodafinil	Nuvigil		
Modafinil	Provigil		
PLEASE LIST OTHER MEDS TRIED FOR PSYCHIATRIC PURPOSES (REASON ALSO)			

Notice of Privacy Policies and Practices

The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully.

- Your private healthcare information may be released to other healthcare professionals within Helios Psychiatry and Counseling for the purpose of providing your mental health care
- Your private healthcare information may be released to your insurance company for the purpose of Helios Psychiatry and Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by Helios Psychiatry and Counseling to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Helios Psychiatry and Counseling is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- Helios Psychiatry and Counseling will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Helios Psychiatry and Counseling:

  Helios Psychiatry and Counseling
  ATTN: Practice Manager
  30472 23 Mile Rd
  Chesterfield, MI 48047

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency. For further information about this Privacy Notice, please call us at 586-863-4000.

HELIOS
PSYCHIATRY & COUNSELING

Client Bill of Rights

• Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or handicap. The personal dignity of each client is recognized and respected in all care or treatment provided.
• Each client has the right to accept or refuse all or part of his/her care and/or have the expected consequences explained.
• Each client has the right to exercise personal privacy by withholding consent or family's or significant other's participation and to be informed of the possible consequences of that action.
• Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
• Each client has the right to participate in the development of their plan of treatment, evaluate the plan of treatment and voice grievances without fear of negative impact on the service provided and be aware of the process of voicing those grievances.
• It is the right of each client to receive individualized treatment which includes:
    o Adequate and humane services regardless of the source of financial support.
    o Services provided in the least restrictive environment possible.
    o An individualized treatment plan which is reviewed periodically and as needed.
    o To be treated by competent, qualified and experienced professional clinical staff who are supervised as appropriate.
• If at any time during the course of treatment it is felt by client, the family, or surrogate decision maker that a care-related conflict exists between themselves and the agency - they have the right to request the opinion of or have their plan reviewed by a staff consultant or an independent consultant at his/her expense.
• The client has the right to request a referral for services which the organization does not provide, to be involved in the discharge planning process, and be aware of any aftercare needs.
• The client will be informed of his/her rights in a language they can understand.
• Each client has the right to refuse to participate in any research projects without compromising their access to the organizations resources.
• Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
• Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.

Recipients have rights protected by state and federal law and promulgated rules. For information contact:

Office Manager
30472 23 Mile Road
Chesterfield, MI 48047

Code of Conduct for Patients

To provide a safe and healthy environment for staff, visitors, patients and their families, *Helios Psychiatry and Counseling* expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- If you have any questions about the care or our unhappy with the service received in our office, please contact our Team Lead before you leave our office so that any clarifications about your care or the services you received can be addressed.
- Please communicate all issues that you wish to discuss with the clinician at the time your appointment is scheduled, so that an appropriate amount of time can be allotted. If you do not do this in advance, another visit may be necessary so that the clinician can give all patients the time and quality of care they deserve.
- Questions about your billing can be addressed first with our Patient Support Specialist, and then with Elite Medical Billing.
- High balances will be investigated. Unless an agreed upon payment plan is set up and adhered to, there may be a disruption of services if the amount reaches $300 or more.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Adults are expected to supervise their children.

The following behaviors are prohibited:

- Possessing firearms or any weapon
- Intimidating or harassing staff or other patients
- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
- Physically assaulting or threatening to inflict bodily harm
- Making verbal threats to harm another individual or destroy property
- Damaging business equipment or property
- Making menacing or derogatory gestures
- Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

_____ _____

Signature Date

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover
Cardholder Name (as shown on card): _____
Card Number: _____ CVV: _____ (3 digit code on back of card)
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Hetal Patel, MD, PC (d/b/a Helios Psychiatry and Counseling) to charge my credit card above for agreed upon services. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

HELIOS
PSYCHIATRY & COUNSELING

Request/Authorization for Release of Information

I _____ hereby authorize Helios Psychiatry and Counseling to release information contained in client records to the following individual(s) and/or organizations(s), and only under the conditions below:

- Name of person(s), organizations(s), address to who disclosure is to be made:
  _____ Attention: _____
  _____
  _____

- □ Disclose entire record

  OR:

  □ Diagnosis □ Drug/Alcohol History □ Treatment Summary
  □ Attendance □ Mental Status Exam □ School Records
  □ Progress □ Physical Examination □ Prognosis
  □ Discharge Summary □ Other: _____

- Purpose of disclosure:

  □ Continuity of Treatment □ P.O./Attorney/Judge/Court □ Provision of Mental Health Services
  □ Aftercare Planning □ Billing Purposes □ Family Involvement

- Without expressed revocation, this consent expires 90 days after discharged from treatment.

- This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

_____ _____

Name of Patient Patient's DOB

_____ _____

Client (Guardian) Signature Date

_____ _____

Staff Signature Date

Revised 2/9/2023

HELIOS
PSYCHIATRY & COUNSELING

Request/Authorization for Release of Information

I, _____, hereby authorize _____ to release information contained in client records to the following organizations, and only under the conditions below:

- Name of person(s), organizations(s), address to who disclosure is to be made:

  Helios Psychiatry and Counseling
  35054 23 Mile Road, Suite 104 Phone: 586-863-4000
  New Baltimore, MI 48047 Fax: 586-863-4004

- □ Disclose entire record

  OR:

  □ Diagnosis □ Drug/Alcohol History □ Treatment Summary
  □ Attendance □ Mental Status Exam □ School Records
  □ Progress □ Physical Examination □ Prognosis
  □ Discharge Summary □ Other: _____

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  □ Continuity of Treatment □ P.O./Attorney/Judge/Court □ Provision of Mental Health Services
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_____ _____

Patient's Name Patient's DOB

_____ _____

Client (Guardian) Signature Date

_____ _____

Staff Signature Date

Revised 2/9/2023

HELIOS PSYCHIATRY & COUNSELING
PATIENT FINANCIAL RESPONSIBILITIES

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- As a courtesy, Helios Psychiatry confirms what insurance carriers that the practice accepts. It is the **patient's responsibility** to confirm if an Individuals policy is in network with Helios Psychiatry. Staff will work with patients on obtaining authorizations for select insurance carriers. A quote of benefits is not a guarantee of benefits or payment.

- We highly recommend you also contact your insurance carrier and check into your coverage for psychiatric and behavioral health services and treatment. Do not assume that you will not owe anything if you have more than one insurance policy.

- It is the policy of Helios Psychiatry that full payment is due **at the time of service** unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the end of your visit with us you may be billed for any outstanding balances. Payment plans must be arranged for outstanding balances or the account will be sent to a collection agency. Any credit can be applied to future services.

- If you are covered by health insurance with psychiatric benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

- Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred: your physician's referral and verification of your insurance benefits are not a guarantee of payment.

- Helios Psychiatry is happy to complete forms as needed for patient care. We ask that you allow at least 5 business days for forms to be completed, and additional time if they need to be returned via mail. Please ensure that all patient information is complete including insurance information. Fees will be assessed as follows:
  - 1-2 page form: $30
  - 3 or more pages: $60

- Any Disability, FMLA, or government **forms** for any New Patients will require **2 - 3 office appointments** for proper evaluation and assessment by provider. Established patients must come in for a consult as these matters cannot be handled over the phone. This is not a guarantee of approval/ denial for such legal forms as it is up to the Provider's discretion for authorization.

- **Active Balance Policy:** We will not schedule patients who carry a balance larger than $300, unless a payment plan has been set up with our Patient Support Specialist and is being adhered to. Payments must be made in a timely manner.

- **Medical records request** – Paper copies will be charged as follows: $1.00 per page for the first 20 pages; $0.25 each for every additional page. Patient is responsible for postage or shipping fees. Payment must be received in advance.

- **No-Show Policy**: A "no-show" is someone who misses an appointment without a **24 hour notice**. Failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show". Patients will be billed a **$75 fee** and will be required to pay this fee in full prior to scheduling another appointment. Three no-show visits may result in discharge from our practice.

1. The insurance information I have provided is accurate and complete. ____

2. I understand that it is my responsibility to check with my insurance provider to understand what services are covered. ____

3. I accept the responsibility for fees, co-pays, deductibles, and changes in insurance for all services rendered to me. ____

4. I understand that I am responsible for the cost of my treatment and that I will be billed directly if insurance claims are rejected or denied. ____

5. I understand that established appointments are reserved for me and that I may be subject to the usual and customary charges for late arrival and all appointments missed or cancelled without 24-hour notice. ____

Signature of Client or Guardian: _____ Date: _____

Permission for Telehealth Visits

What is telehealth?

- Telehealth is a way to visit with healthcare providers, such as your doctor, physician associate or nurse practitioner.
- You can talk to your provider from any place, including your home.
- The location exception would be, if you are driving. This is a safety issue to you and others. We will not complete any appointments while you're driving a vehicle.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- You use video and audio so you and your provider can see and hear each other.
- There are no apps to download.
- Helios Psychiatry and Counseling uses our website for accessing telehealth appointments using Doxy. Doxy is a secure telemedicine platform.
- A few minutes before your scheduled appointment, you will need to visit our website at www.heliospsych.com. Scroll down to your Provider/Therapist, and click on the link that says 'CLICK HERE' under their picture, and follow the instructions. You will need to agree to allow access to your camera and microphone. This allows you to see and hear each other.
- Call the office immediately, if you have any problems signing in for your scheduled appointment.

How does telehealth help me?

- You don't have to go to the office to see your Provider/Therapist.
- You won't risk getting sick from other people.
- It's convenient if you are unable to drive or get a ride to an appointment.
- It can be easier to fit into your schedule.

Are there any downsides to telehealth?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider/therapist.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit?

- You can request in office appointment instead of telehealth. You may have to wait a little longer for an in-office appointment.

What if I try telehealth and don't like it?

- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
    - call 586-863-4000 and let staff know that you need an in-office appointment.

How much does a telehealth visit cost?

- What you owe depends on your insurance benefits.
- We do not charge any more for telehealth visits than an office visit.
- If your provider/therapist decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Why am I signing this document?

- In case the weather is bad, we can call you and change your in person appointment to telehealth. This way you won't miss your appointment. You can still reschedule if you prefer in person.

What does it mean if I sign this document?

By signing this document, you agree that:

- You understand the requirements to having telehealth visits.
- You understand that you cannot be driving a vehicle during a telehealth appointment.
- You understand that you need to be in a location with good cellular service and/or strong WIFI signal.
- Understand that your provider may decide you still need an office visit.
- We answered all your questions.
- You agree that you are responsible to attend your scheduled appointment or call 24 hours prior to cancel.

Your name (please print) Date

Your signature Date

HELIOS
PSYCHIATRY & COUNSELING

January 03, 2023

WAIVER OF INSURANCE BILLING

You have registered as a cash/private pay patient. This means that at the time of service you will be paying by cash, check, or credit card. You understand that due to this cash payment, you are receiving a discount. Helios Psychiatry & Counseling will not bill insurance for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

You agree to: 1) pay at the time of service, and 2) waive insurance billing by Helios Psychiatry & Counseling 3) notify Helios Psychiatry & Counseling of a desire to change this agreement prior to private payment for a session.

Further, you attest that you do not have Medicaid for insurance purposes, as Federal law disallows Medicaid clients from paying out of pocket for these services.

Name: DOB:

Signature: Date:

Provider Name: To be scheduled	
Provider Address: 30472 23 Mile Rd, New Baltimore, MI 48047	
Provider Phone #: (586)863-4000	Clinic Group NPI #: 1447672944
Clinic Tax ID#: 462781294	

Patient Name:	Date of Birth:
Patient Diagnosis: Pending	
Services Requested: Psychiatric Evaluation CPT: 90792; Outpatient visit CPT: 99214 Therapy Evaluation CPT: 90791; Therapy follow-up CPT: 90837	

You are entitled to receive this "Good Faith Estimate" of what the charges could be for psychiatric services provided to you. While it is not possible for a provider to know, in advance, how many psychiatric sessions may be necessary or appropriate for a given person, this form provides an estimate of the cost of services provided. Your total cost of services will depend upon the number of psychiatric sessions you attend, your individual circumstances, and the type and amount of services that are provided to you. This estimate is not a contract and does not obligate you to obtain any services from the provider(s) listed, nor does it include any services rendered to you that are not identified here.

This Good Faith Estimate is not intended to serve as a recommendation for treatment or a prediction that you may need to attend a specified number of psychiatric visits. The number of visits that are appropriate in your case, and the estimated cost for those services, depends on your needs and what you agree to in consultation with your provider. You are entitled to disagree with any recommendations made to you concerning your treatment and you may discontinue treatment at any time.

The fee for an outpatient psychiatric visit (in-person or via telehealth) is $275.00 and for the evaluation and $120.00 for follow-up sessions. The fee for a therapy evaluation (in-person or via telehealth) is $225.00 and $120.00 for follow-up sessions. Most patients will attend one visit per month, but the frequency of psychiatric visits that are appropriate in your case may be more or less than once per month, depending upon your needs. Based upon a fee of $120.00 per visit, if you attend one visit per month after your evaluation, your estimated charge would be $1440.00 for twelve visits provided over the course of one year. If you attend medication management for a

longer period, your total estimated charges will increase according to the number of visits and length of treatment.

You have a right to initiate a dispute resolution process if the actual amount charged to you substantially exceeds the estimated charges stated in your Good Faith Estimate (which means $400 or more beyond the estimated charges).

You are encouraged to speak with your provider at any time about any questions you may have regarding your treatment plan, or the information provided to you in this Good Faith Estimate.

Date of this Estimate: 1/3/2023

HELIOS
PSYCHIATRY & COUNSELING

I acknowledge that I have received and reviewed the following forms:

Notice of Privacy Policies and Practices
Client Financial Responsibilities
Client Bill of Rights
Code of Conduct for Patients
Permission for Telehealth
Billing Waiver/Cash Pay/Good Faith Estimate

I have been encouraged to ask any questions about the forms.

_____ _____

Printed Name Date

_____

Patient or Legal Guardian's Signature

Revised 2/9/2023