Pearl Health Clinic, PLLC

2705 E 17TH ST • Ammon, ID 83406 • 208.346.7500 • fax 208.346.7501

NEW PATIENT INTAKE PACKET

Patient's Information: **Today's Date:** 29/04/2016

Last Name: Barney First Name: Chad

Street Address: 2292 Wheatgrass Road City: American Falls State: ID Zip: 83211

Home Phone: 12082262284 Work Phone: 12082262284 Cell Phone: 12082262284

DOB: 30/11/1996 Age: 29 Sex: Male Marital Status: Single *Language Spoken: English

Are Interpreter Services Needed: ○ Yes ◉ No If **Yes What services are needed:

Ethnicity/Race: ◉ Caucasian ○ Native American ○ African American ○ Hispanic ○ Asian ○ Pacific ○ Other American Falls

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Responsible Party / Parent(s) **Person completing Intake must be listed first**

Responsible Party's Full Name: **Chad Barney** DOB: **30/11/1997** SS#: **555-55-5555**

Employer's Name and Address: **2292 Wheatgrass Road**

Work Phone#: **12082262284** Occupation: **Clinic Bitch**

2nd Responsible Party's Full Name: DOB: **dd/mm/yyyy** SS#:

Employer's Name and Address:

Work Phone#: Occupation:

Emergency Contact: Name: **Phone:** **Relation:**

Who referred Patient to this practice? **Mother Hen**

Who is Patient's Primary Care Physician? (Name, Address, and Phone)

Witch Doctor

Are there any other Doctor's treating you at this time: **Voodoo Master**

Administrative Use ONLY: Date Received: Staff Initials:

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Primary Insurance Carrier:

Name: **Self**

Phone: **2083467500**

Policy Holder (PH): **Chad Barney**

Relationship of PH to you: **Self**

PH DOB: **dd/mm/yyyy**

PH SS#: **555555555**

Policy ID#: **AF223452**

Group#: **AAA111**

Secondary Insurance Carrier:

Name:

Phone:

Policy Holder (PH):

Relationship of PH to you:

PH DOB: **dd/mm/yyyy**

PH SS#:

Policy ID#:

Group#:

***If you are without insurance**, you may opt to see an Intern (based on availability) or apply for a **Hardship Waiver**. To apply for a Hardship please submit one of the following, with your Intake Packet.

1. **Last current tax filing information (First two pages), if you filed.**
2. **Two current month's of Payroll Stubs, if employed.**
3. **Two current month's of Bank Statements.**

We must have "total family income" so if submitting payroll stubs; we need both spouses' copies. If you're on SSDI and your spouse is employed, we will need the SSDI Letter and other parties' payroll stubs. All income requirements are based on the **Federal Poverty Guidelines**. Upon signing the Insurance Release (page 5), you are acknowledging that you are aware of PHC's Hardship Waiver requirements.

****All** Non Medicaid Patient's requesting **Suboxone Treatment** are subject to a $400 deposit, as not all insurances cover Substance Abuse Treatment. This deposit is **MANDATORY** regardless of your insurance coverage. If your insurance covers some or all, of your treatment, you **MAY** be eligible to a refund. Refunds and refund amounts are handled through Pearl Health Billing Dept and will be established after your insurance has been billed. Upon signing the Consent to Treat (page 6), you are also acknowledging that you are aware and agree to the payment, of the Suboxone deposit.

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Services Requested:

☐ **Primary Care Medicine** – Family medicine provides continuing and comprehensive health care for the individual and family across all ages, genders, diseases and parts of the body.

☑ **Psychiatric Medicine** – Psychiatry is the medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. These include various affective, behavioral, cognitive and perceptual abnormalities.

☑ **Neuropsychological/Psychological Testing** – Measure and evaluate neuropsychological factors, such as memory, and psychological factors, such as personality. Aids in diagnosing conditions such as developmental disability, dementia, and personality disorder. Helps differentiate between diagnoses, such as ADHD and bipolar. Aids in developing treatment plans.

☐ **Counseling** – A relatively shortterm, interpersonal, theory based process of helping persons who are basically psychologically health, but need help in resolving developmental and situational problems.

☑ **Neurofeedback Therapy** – A non-invasive alternative way of improving your quality of life. The electrical activity of your brain is monitored through a software program that lets you, the client, see the activity of your brain on a monitor.

☐ **Eating Disorder Therapy** – We offer individual, family, and group therapy for bulimia, binge eating disorder, and anorexia. Additionally, we offer weekly Mindful Movement and monthly Mindful Eating groups.

☑ **PTSD Clinic** – PTSD Assessment; Individual and family therapy; Different groups: Trauma Recovery, Anger Management, Trauma and Substance Use Disorder Recovery.

☐ **Community Based Rehabilitation Services (CBRS)** – Gaining and utilizing skills necessary to function adaptively in home and community settings and attain or retain capability for independence. (Medicaid Insurance Only)

☐ **Substance Abuse Program** – This outpatient program involves weekly group therapy sessions, weekly or biweekly or monthly individualized counseling as determined by treatment plan, and regular medication management appointments.

☐ **Case Management** – Assisting people with mental illnesses in obtaining the basic services required to live as independently as possible in their communities. The goal is to ensure an individual is receiving the support they need while working to increase the individual's ability for self-support. (Medicaid Insurance Only)

☐ **Pearl Supportive Living** – A Residential Habilitation (Res-Hab) agency that provides assistance to developmentally disabled individuals who need supportive living services.

Requesting specific medical personnel/counselor?

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Current Problem: (Please explain why the patient needs to be seen in our office?) If you need help describing the current problem, please go to www.nlm.nih.gov/healthtopics.html (http://www.nlm.nih.gov/healthtopics.html) for a list of health topics.

I need more voodoo

List all CURRENT Medications: (Additionally, list all medications taken in the last 2 years)

The Good Stuff

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Insurance Release And Cancellation Policy

Welcome to Pearl Health Clinic!! We look forward to assisting you and making your visit, to our office, a positive one. In an effort to prevent passing increased operational costs, to our patients, **we request payment at the time of service unless you have a contracted insurance plan**. Please understand that payment(s), for services that you receive, are a part of your treatment. The fees we charge are determined by historic "usual and customary" fees, for our geographic area. We will do everything we can to aid you in receiving the maximum allowable benefits, from your insurance carrier; **however you are ultimately responsible for your account**.

PHC is a contracting provider with most insurance carriers and we will bill your insurance accordingly. **Any balance due will be your responsibility (excluding MEDICAID patients).**

Your insurance coverage is your responsibility. We will verify benefits, however any unpaid balances, after contractual adjustments (if applicable), will be your responsibility. Some insurance plans requir that the patient contact them for Prior Authorization. This is your responsibility and not PHC's and failure to contact them, as required, may result in you being responsible for the full amount, of your charges. If you have questions about your coverage, please contact your insurance carrier. Providing PHC with **current and accurate** insurance information will allow us to obtain the quickest response, from your insurance. **We do not participate with all insurance carriers**. This means your insurance may not cover services at the same rates, as if you were seen by a participating provider.

We will accept Medicare Advantage (Med Adv) for all services. Please notify the Intake Dept if you have a Med Adv plan, by supplying a copy of the applicable card.

We will accept Medicare Advantage (Med Adv) for all services. Please notify the Intake Dept if you have a Med Adv plan, by supplying a copy of the applicable card.

For Minor Patients or those with Legal Guardians, the Parent/Guardian and/or Guarantor is responsible for the payment, at the time of treatment. Unaccompanied Minors **MUST** have pre-authorization, from the Parent/Guardian. Payment is expected at the time of service. The Parent(s)/Guardian(s), presenting the patient for treatment, is the responsible party for all balances due. Please note that statements will only be sent to the Responsible Party, as indicated on the Patient's Intake.

If you have a credit balance, a refund check will be issued to you immediately.

For plan specific information, please contact your insurance carrier, directly.

A 24 HOUR CANCELLATION NOTICE IS REQUIRED FOR ALL APPOINTMENTS!!!!!

**If you miss your appointment, a fee of $50 will be charged to the patient's account. The Patient, Parent/Guardian, and/or Guarantor will be responsible for the payment of this fee, before additional appointments are scheduled. If you miss a total of THREE (3) appointments, you will be dismissed from the practice. THIS INCLUDES MEDICAID PATIENTS.

ASSIGNMENT AND RELEASE

◉ Non Medicare: I hereby assign my insurance benefits, to be paid directly to Pearl Health Clinic. I understand that I am financially responsible for any non-covered services (including those with MEDICAID). I also authorize Pearl Health clinic to release any informationrequired to process my claims." "Medicare: I request the payment of authorized Medicare benefits to be made on my behalf to Pearl Health Clinic. This payment should include payments for services provided to me, by Pearl Health Clinic and its affiliate Providers. I authorize the release of my personal medical information, to the Centers for

○ Medicare and Medicaid Service (CMS) and its agents. The release of said information shall be used to determine benefits or the benefits payable for related services. This authorization is effective until I choose to revoke it, in writing.

Printed Name: **Chad Barney** Date: **29/04/2016**

Signature (if under 18 must be Parent/Guardian): **Chad Barney** Relation: **Self**

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CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

If you do not sign this consent form, agreeing to what is our Notice of Privacy Practice – WE CAN NOT TREAT YOU!!

This form is an agreement between you, "Chad Barney " and Pearl Health Clinic. When we use the term "you" below, it will mean child, relative, or other person documented above.

When we examine, diagnose, treat, or refer you to another provider, we will be collecting Protective Health Information (PHI) about you. We need to use this information to decide what treatment(s) are best for you and to provide treatment(s) to you. We may also share this information with others who provide treatment to you, need it for payment information, or for other business/government functions.

By signing this form, you are agreeing to let us use information and share it with others. Additionally, you are agreeing to the access/review of your **EXTERNAL** prescription history, from local and national pharmacy database systems. Pharmacy information will only be used internally, for your healthcare, and will not be release or shared without your consent, unless deemed medically necessary. **PEARL HEALTH CLINIC IS NOT A PAIN MANAGEMENT CLINIC**.

The Notice of Privacy Practice explains your rights and how we can use and share your information. Please read this before you sign this Consent.

Disclosure of your information is your right except when processing claims, as it's necessary for payment. You have the right to ask us to not disclose specific information for treatment, payment, and/or administrative purposes. These requests must be requested in writing and we will try to respect your request, although we are not obligated to do so, for specific purposes. If an agreement is made, we will comply with your request.

After you have signed this consent, you have the right to revoke it. This must be submitted in writing and will be processed through the Reception Staff. Disclosure of your information will cease, effective the date of the letter revoking consent. Any information disclosed on or before revoking consent, cannot be changed.

◉ I request a copy of the Notice of Privacy Practice. (Please mark here if you would like a copy of the Privacy Notice)

○ I do not require a copy. (A copy may be requested at a later date)

I understand that if I am the Custodial Parent or Guardian, medical record information will be released only upon my request. You may sign and complete a written Release of Information, which will be maintained on file with Pearl Health Clinic. This release shall indicate who this information shall be disclosed to. Please note that Non Custodial Parents or Guardian's with appropriate legal documentation shall have access to these records, regardless if there's a release on file.

I authorize the following people to have access to my medical information:

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Name: _____ Relationship: _____ Name: _____ Relationship: _____

Patient's Name: **Chad Barney** Date: **29/04/2016**

Signature of Patient (or Parent/Guardian) **Chad Barney** Print Name (if not Patient) **Chad Barney**

Relationship to Patient ○ Self ○ Parent ○ Guardian ○ Other Legal Relationship

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