Quality Mental Health Services

Karlton Nicholson PMHNP-BC
Althein Nicholson PMHNP-BC
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Fax# 623-263-2917
QMHSLLC.com (website)
qhmsllc.22@gmail.com

Patient's Name _____

Date of birth ____ / ___ / _____

Address _____

City _____ State _____ Zip _____

Home phone _____ ok to leave a message? Y / N

Cell phone _____ ok to leave a message? Y / N

Marital status (circle one) married divorced never married separated other

Emergency Contact Name and Phone - _____
_____

INSURANCE INFORMATION

(Note: this portion not applicable if paying for services out-of-pocket)

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

Policy Owner: _____

Policy owner DOB: ____ / ___ / _____ Policy Owner Social Security # _____

Policy Owners relationship to patient _____

Insurance Company Name _____

Policy/member #Group # _____Copay amount $_____ Co-Insurance% _____ Deductible yet to be satisfied $( ) Unknown _____

Policy Owner Address _____

Policy Owner Phone Home/Cell _____Work _____

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

I authorize Quality Mental Health Services LLC (QMHS) to release the insurance company information needed to determine benefits payable for related services.
I request that payment of authorized insurance benefits be made to QMHS for services furnished to me by QMHS.

_____
(Signature of insured or responsible party)

_____
(Date signed)

CONSENT FOR TREATMENT

I authorize the therapeutic services for _____

The therapeutic relationship is a very personal one. This document has been designed to guarantee a mutual understanding between all parties involved regarding services offered and ultimately provided. It is important that you read this document carefully and discuss any questions or concerns with the Provider. Signing this document signifies an agreement between you and **QMHS**, who provides psychiatric and mental health services, to include counseling, laboratory and medication management. You may withdraw this agreement at any time, if you chose to do so. By discussing private and often sensitive issues with a trusted professional in a confidential setting, patients are often able to free themselves from those difficulties which have prevented their abilities to attain joy, happiness, and success. The freedom to be open and honest about such topics is essential for therapeutic success; however, talking about sensitive issues can be difficult to ensure, oftentimes causing stress and distress. It is imperative that communication channels are utilized. Please do not hesitate to communicate to your Provider if you find yourself experiencing any form of distress as soon as possible. There are risks and benefits to mental health treatment. You are free to review your treatment plan at any time and if you disagree with any aspect of it you are invited to discuss the goals with the Provider who will try to offer an acceptable alternative treatment plan. Should you refuse the recommendations, Provider may elect to withdraw services.

Patient Signature _____ Date _____

_____ A "Psychiatric Evaluation" consists of a 60–90-minute session. NO-SHOWs or cancelations made less than 24 hours in advance will require full payment for that session. If late, the session will not be extended past the allotted 60 minutes and a follow up Psychiatric Evaluation will need to be scheduled.

_____ A "Med Check" consists of a 20 to 45 minutes session (depending on complexity). NO-SHOWs or cancelations made less than 24 hours in advance will require full payment for that session. If late, the session will not be extended past the allotted time.

_____ Due to the nature of the therapeutic process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client's) nor your attorney, nor anyone else acting on your behalf will call on QMHS's providers to testify in court or at any other proceeding, nor will a disclosure of the psychiatric records be requested unless otherwise agreed upon.

_____ All information disclosed within sessions and the written records pertaining to those sessions <u>are confidential</u> and may not be revealed to anyone without your (client's) written permission, except where disclosure is required by law.

When Disclosure Is Required by Law: Some of the circumstances where disclosure is required by the law are where there is a reasonable suspicion of child, dependent or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled or when client's family members communicate to QMHS that the client presents a danger to others.

_____ QMHS consults regularly with other professionals regarding their clients; however, client's identity remains completely anonymous, and confidentiality is fully maintained.

If you need to contact your provider between sessions, please leave a voice or text message for QMHS at (623) 693-4826 and your call will be returned as soon as possible.
Providers check their messages several times during the daytime only, unless they are out of town. If an emergency arises, indicate it clearly in your message and if you need to talk to someone right away call Empact 24-hour suicide prevention center 480-784-1500 or the Police: 911. Please do not use e-mail or faxes for emergencies. Your Providers do not check their e-mail or faxes daily.

_____ Requests for copies of records must be made in writing and require 10-14 days.

FEE SCHEDULES INSURANCE INFORMATION

_____ Intake/Initial Psychiatric Evaluation fee $275.00

_____ Med Check/Follow Up visits $125.00 (only applicable until insurance services are obtained by provider)
_____ Telephone Consultation (with parents, doctors, school staff, case workers, parenting coordinators & other professionals) $50 per 15 minutes

_____ Treatment/medication summary letter, letter of clinical recommendations, school form completions, disability paperwork, and other report requests $25 per page

_____ Copy fee $50.00 per request

_____ NO-SHOW or cancel less than 24 hours in advance $125.00

_____ Returned check fee $35.00

_____ Acceptable forms of payment are Most Major Insurance Plans (please check prior to initial Evaluation), Cash, Check, Debit or Credit Card. If using private insurance, they will be billed on the date of service. All copays, session fees and additional charges are due at the time of service unless otherwise stated.

_____ Unpaid charges will be turned over to collections after 90 days of non-payment.

_____ It is your responsibility to verify eligibility, deductible, coverage and copay amounts with your insurance carrier prior to the initial appointment. If for any reason insurance claims are denied, it is your responsibility to pay the service fee in full. _____ Court appearance if subpoenaed by court (2 hour minimum) $300.00 per hour.

PLEASE NOTE: QMHS IS NOT TO BE CALLED FOR COURT TESTIMONY. WE DO NOT SPECIALIZE IN THIS FIELD AND WILL NOT BE ABLE TO ACCOMMODATE THIS REQUEST. IF QMHS is SUBPOENAED TO COURT, CHARGES WILL BE $300.00 PER HOUR (2 HOUR MINIMUM)**
I have read this form, been given the option of a copy, discussed any questions with QMHS and agree to its terms.

Printed Name _____

Signature _____ Date _____

Quality Mental Health Services
Karlton Nicholson PMHNP-BC
Althein Nicholson PMHNP-BC
(480) 849-7705
QMHSLLC.22@gmail.com

PRIVACY POLICY

PROTECTING YOUR PRIVACY

To increase your privacy, confidentiality and security: Establishing a therapeutic relationship is a valuable tool. When it comes to discussing private and sensitive information, talking with a trusted professional in a confidential setting, is often why people feel good about releasing themselves from the worries which may be repressing their abilities to obtain joy, happiness and success. The freedom to talk openly and honestly about their struggles is essential for therapeutic progress. It is vital that you are aware of the risk involved in breaches of privacy and confidentiality

when other entities have access to this information. These may include (but are not limited to) your insurance company, medical personnel, disability care managers, Workman's Compensation, or attorneys.

Risks may include:

- Your diagnosis impacting future insurance coverage should you change insurance carriers voluntarily or via job change.
- Increased potential for identity theft through the sharing of social security numbers or other personal information.
- Computer or other errors resulting in accidental release of information.

You are always welcome to use your insurance, sign Releases of Information, and/or ask for assistance in working with disability claims or Workman's Compensation paperwork, however, when you pay privately you eliminate or significantly reduce the potential risks mentioned above. When treatment and discussions are only between you and your provider, the situation is simplified: your Provider is legally and ethically bound to maintain confidentiality laws and you are in control of whom you choose to share information. (An exception would be legally mandated reporting of child/elder abuse, threats to harm self, or threats to harm others.)

NOTICE OF PRIVACY PRACTICES

Our practice is dedicated to maintaining the privacy of your personal health information as part of providing professional services and mental healthcare. We also are required by law to keep your information private. Although these laws appear complicated, we are required to provide you with this valuable information.

We will use the information regarding your health, which may be obtained from you or others, to provide the best care for treatment, to arrange payment for said services, or to perform other business activities which are a part of health care operations, as described by law. After you have read this disclosure, we will request that you sign a Consent Form allowing us to use and/or share your information.

For any other purposes requiring disclosure (send, share, release) of your information, we can discuss the issue and ask that you sign an Authorization to Release information form which details the request. Keeping your health information private is our priority, however there are times when the law requires the usage and/or sharing of data. For example:

1. When there is a serious threat to your, another individual, or the public’s health and safety, we will only share information with a person or organization that is able to help prevent or reduce said threat.
2. Involving some lawsuits, legal or court proceedings.
3. If a law enforcement official requires assistance.
4. For Workers Compensation and/or similar benefit programs. Although they may not happen very often, please be aware that situations like can arise.

RIGHTS REGARDING YOUR HEALTH INFORMATION

You can ask us to communicate your health and related issues to you in a more suitable way or in a place that provides privacy. For example, you can ask us to call you at home, and not at work to schedule or cancel an appointment. We will try our best to accommodate your request.

You have the right to determine who can receive details and information (such as family members and friends), when questions arise involving your care or payment for services. We want to ensure your privacy is respected; however, it is our responsibility to abide by the laws and do what is required in the case of an emergency or providing essential treatment.

You have the right to request your health information, such as medical or billing records. We are happy to provide copies of these records for a fee.

If you find errors in the information found in your records, or there is incorrect or missing important information, you can request changes (called amending) in writing explaining your reasons for the changes.

You have the right to obtain a copy of this notice. If there are any changes to this NPP, we will gladly provide a new version when requested.

If you suspect that your privacy rights have been violated, please be aware that you have the right to file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be in writing. Please be aware the filing a complaint will not affect the healthcare services provided to you.

If you have any questions regarding this notice or our health information privacy policies, please contact:

Quality Mental Health Services
1360 N. Bullard Ave, Ste 200
Goodyear, AZ 85395
Phone: 480-849-7705
Qmhsllc.22@gmail

CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION

This form is an agreement between (patient) _____ and QMHS

When we examine, diagnose, treat, or refer you, we are attempting to collect data that is legally Protected Health Information (PHI). We need to use this information to decide on what treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you agree to allow QMHS to utilize and share your information to others for business purposes. Our Notice of Privacy Practices details your rights and explains how we may use and share your information. Please read this before you sign this Consent form.

Please contact us if you have questions or concerns regarding the terms of agreement in our Notice of Privacy Practices.

Please be aware that there may be times when we must modify how we use and share your information, at which time we may change our Notice of Privacy Practices. If needed, you can get a copy of our Privacy policies by calling our office.

If there is a concern regarding any of your information, you have the right to request that your information not be used or shared for treatment, payment, or administrative purposes. However, you will have to submit your request in writing. We will strive to accommodate any request made in good faith, although we are not required to agree to the terms.

After you have signed this consent, please be aware that you have the right to revoke your consent (in writing rescinding your consent) and we will comply with your wishes regarding using or sharing your information from that time on. However, please keep in mind that we may have already used or shared some of your information, which cannot be changed.

_____

Signature of patient or guardian Date

_____

Printed name of patient or guardian Relationship to patient (if applicable)

_____

Description of representative's authority (Guardian/Parent/Self)

Authorization for Release of Information

I, _____hereby authorize
(Print patient, former patient, parent/guardian or another authorized person)

QMHS c/o **Karlton Nicholson, Althein Nicholson,** or other company agent (please check boxes below)

[ ] Disclose information to

[ ] Obtain information from

Regarding: _____ _____ ____/___/_____
(Patient name) (Social Security Number) (DOB)

Recipient: I authorize the release of my health information to the following recipient:

Recipient Name: _____

Address: _____

City_____ State_____ Zip: _____

The following information may be disclosed:

___Case Summary

___Discharge Summary & Treatment Plan

___Progress Notes

___Reciprocal verbal communication

___Other

Purpose of disclosure: _____Expiration date: _____

To the party receiving this information: If the records disclosed pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, and/or psychiatric, mental health information, the information has been disclosed from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. This authorization is subject to revocation at any time by written notification to Quality Mental Health services and will automatically expire on the above date or one year from the date on which it was signed. In consideration of this authorization, I hereby release the above parties from any legal liability resulting from the release of this information.

Signature: _____ Date: _____
(Patient, former patient, parent/guardian or another authorized person)

Witness: _____Date: _____