Healthy Minds Behavioral Health Clinic

9492 W Fairview Ave, Boise, ID 83704

Fax # 2082133659

Phone #2082847100

Email info@healthyminds.clinic

Date | **Patient First and Last Name**

Home Phone | **Cell Phone**

DOB | **Gender** | **Email Address**

Address

City | **State** | **ZIP Code**

Occupation | **Marital status**

Emergency name | **Contact**

Primary Insurance policy holder Name | **Insurance company Name**

Insurance Group # | **Insurance policy #**

Members service phone # | **SSN#**

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1. Patient Rights and Responsibilities

- **Patient Rights:**
  - To receive respect, dignity, and privacy.
  - To receive information about their treatment options and to be involved in decisions regarding their care.
  - To be informed of the risks, benefits, and alternatives of treatment.
  - To maintain confidentiality, except where disclosure is required by law or necessary for treatment.
  - To have access to their medical records as permitted by law.
  - To file a complaint or grievance about care provided at the clinic.
- **Patient Responsibilities:**
  - To provide accurate, complete, and current personal and health information.
  - To actively participate in treatment, including following prescribed treatments and attending scheduled appointments.
  - To communicate openly with the Psychiatric Nurse Practitioner about any issues or concerns regarding treatment.
  - To respect the clinic's rules, policies, and the rights of other patients and staff.
  - To inform the clinic about changes in contact information and insurance coverage.
  - To provide at least 24 hours' notice if unable to attend a scheduled appointment.

2. Appointment Scheduling and Cancellations

- **Scheduling Appointments:**

- Patients may schedule appointments by calling the clinic's front desk or via the online scheduling system.
- New patient appointments will require an initial intake assessment, which will be scheduled at the first available opportunity.

- **Cancellations and No-Shows:**
  - We ask patients to cancel appointments at least 24 hours in advance. Failure to do so may result in a cancellation fee.
  - Repeated no-shows or cancellations may lead to discontinuation of services at the clinic.
- **Late Arrivals:**
  - If a patient arrives more than 5 minutes late for a scheduled appointment, they may be asked to reschedule.

3. Confidentiality and Privacy

- **HIPAA Compliance:**
  - All patient information is maintained in compliance with the Health Insurance Portability and Accountability Act (HIPAA).
  - Confidentiality is maintained throughout all stages of treatment, including in communications and record-keeping.
- **Disclosure:**
  - Any release of information requires written consent from the patient, except when mandated by law (e.g., risk of harm to self or others, or legal obligations).
- **Medical Records:**
  - Patients are entitled to request a copy of their medical records, with reasonable notice, and a fee for copying, if applicable.

4. Medication Management

- **Prescriptions:**
  - Medications will only be prescribed after a thorough evaluation by the Psychiatric Nurse Practitioner.
  - Patients are encouraged to ask questions about their medications, including potential side effects and interactions with other treatments.
- **Refills:**
  - Medication refills will be processed during scheduled follow-up visits. Requests for early refills or medication changes should be discussed during the patient's appointment. Request for refills can take up to 48 hours.
  - Refills will not be given without a current evaluation.

- **Medication Adherence:**
    - Patients are expected to follow the prescribed medication regimen and inform the provider about any concerns regarding adherence or side effects.

5. Billing and Insurance

- **Insurance Verification:**
    - Patients should verify their insurance coverage with the clinic prior to scheduling appointments. We accept various insurance plans and can discuss out-of-pocket payment options.
- **Billing Process:**
    - Payment for services is due at the time of the visit, including any co-payments or deductible amounts.
    - The clinic accepts various forms of payment, including credit cards, debit cards, and personal checks.
- **Outstanding Balances:**
    - Patients with outstanding balances will receive notifications for payment, and continued care may be suspended if financial obligations are not met.

6. Emergency and Crisis Situations

- **Crisis Support:**
    - Healthy Minds Behavioral Health Clinic is not a crisis center. In the event of a psychiatric emergency, patients should contact emergency services (911) or visit the nearest emergency room.
- **After-Hours Care:**
    - Patients requiring urgent psychiatric support after clinic hours can contact the clinic's emergency contact number (if available) or proceed to a local emergency room.
- **Safety Concerns:**
    - If the Psychiatric Nurse Practitioner determines that a patient poses a risk to themselves or others, immediate action may be taken, which may include hospitalization or law enforcement involvement.

7. Behavior and Conduct

- **Respectful Behavior:**
    - Patients and visitors are expected to conduct themselves respectfully toward all staff and fellow patients. Disruptive or aggressive behavior will not be tolerated and may lead to termination of care.
- **Substance Use:**

- The clinic maintains a strict policy prohibiting the use of illegal drugs or alcohol on the premises. Any patient suspected of being under the influence will not be seen for their appointment and may be asked to reschedule.

8. Termination of Care

- **Voluntary Termination:**
  - Patients may discontinue care at any time. However, a formal notification to the clinic is appreciated to ensure proper transfer of care.
- **Involuntary Termination:**
  - The clinic reserves the right to discontinue care for reasons including but not limited to non-compliance with treatment, repeated no-shows, failure to pay fees, or inappropriate behavior.
- **Referral Process:**
  - If the clinic is no longer able to meet a patient's needs, appropriate referrals will be made to other providers or services.

9. Patient Feedback

- **Complaint/Grievance Process:**
  - Patients are encouraged to provide feedback regarding their care. If a patient has a complaint or grievance, they can submit it in writing to the clinic's management or speak directly with the clinic's office manager.
  - All complaints will be reviewed and handled promptly to ensure continued quality care.

Acknowledgment: By signing below, I acknowledge that I have read, understood, and agreed to the policies and procedures outlined above for Healthy Minds Behavioral Health Clinic.

Patient Name and Signature: _____

Date: _____

Witness Signature: _____

Date: _____

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Release of information Authorized for disclosure

First & Last Name: _____ **Patients Phone No.** _____

Date of Birth: _____

Patients Home address _____

Providers office requesting or needing information:

Healthy Minds Behavioral Health Clinic 9492 Fairview Ave, Boise, ID 83704

Fax # 2082133659 Phone #2082847100 Email info@healthyminds.clinic

I authorize the following person or business to release or disclose confidential information about me: Primary Doctor Name or Clinic Name _____

Purpose of Disclosure: Codination of care _____

Type of information to be disclosed ____Psychiatric _____Drug/Alcohol _____ LABS Description of information requested:_____ .

This authorization is good until __X__1 yr. I understand that I am under no obligation to sign this form and the person and/or organization listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan, or eligibility for healthcare benefits or my decision to sign this authorization. I understand that if the person and/or organization listed above are not healthcare providers, health plans, or healthcare clearinghouses that must follow the federal privacy standards that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re-disclosed without my authorization. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization. Copy requested and received _____Yes No _____ I do not want a copy of this. I release the person/agency disclosing this information from any liability arising from the release of information to the agency or person designated above. Federal rules prohibit further disclosure of this information unless expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR Part 2.

Patient or Guardian signature _____Date _____

Witness signature_____ Date _____

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Consent to Treatment / Telehealth/ Financial Responsibility / Autho

rization to Release Medical Information / Assignment of Benefits

I _____ consent to telehealth/ in office treatment to be rendered and, in so doing, agree to be responsible for the payment of professional fees. Such fees or supplemental charges may include, but are not limited to patient copay, deductibles, non-insured services (ie., prescription renewals outside your appointment time, pharmacy authorizations, telephone/email communications, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents as medically unnecessary. If my insurance does not cover the charges, then I am responsible for payment and the credit card on file can be used to make the whole payment. A fee of $25.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service. I authorize health minds behavioral health, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent Healthy Minds Behavioral Health clinic. and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented.

I assign any insurance benefits to Healthy Mind Behavioral Health Clinic

Patients signature_____ Date _____

Witness signature_____.Date _____