

WELCOME TO OUR PRACTICE

Prior to your appointment, we ask that you complete the patient registration prior to your appointment. If complete please arrive 15 minutes prior to the scheduled appointment time.

Also we need you to call your insurance and verify if you need any authorization for your first visit to your office. When calling please specifically ask if your coverage requires Outpatient Mental Health authorization and what your copay or coinsurance is to see our provider.

Lastly, please remember to bring the patient registration completed, your insurance card and photo id (if a child the parents ID). **Failure to bring any of the items will result in your being responsible to pay your visit in full, until which time you are able to provide us with the required items.**

If you have any questions, please contact us at 703-698-5220. Dr. Goldstein's patients please call Maria at ext 319.

Patient Registration Form

Treating Clinician: _____ **Date:** _____

LAST NAME: _____ FIRST NAME: _____ MI _____

SOCIAL SECURITY NO.: _____ DATE OF BIRTH: _____ AGE: _____ SEX: M F

MARTIAL STATUS: S M D W

HOME ADDRESS: _____

(Street) (City) (State) (Zip)

HOME PHONE: () _____ WORK PHONE: () _____ EXT _____

CELL PHONE () _____ REFERRED BY: _____

EMPLOYED BY: _____ OCCUPATION: _____

PATIENT EMAIL: _____

EMERGENCY CONTACT: _____

(Name & telephone number)

Account Guarantor Information (Responsible Party)

LAST NAME: _____ FIRST NAME: _____ MI _____

HOME ADDRESS: _____

(Street) (City) (State) (Zip)

HOME PHONE: () _____ WORK PHONE: () _____ EXT _____

CELL PHONE: () _____

EMPLOYED BY: _____ RELATIONSHIP TO PATIENT: _____

DOB: _____ SOCIAL SECURITY NO. _____

WE ONLY SUBMIT TO INSURANCE CO. THAT WE PARTICIPATE. We will gladly make you a copy of the encounter form for your submission.

INSURANCE INFORMATION (FOR PARTICIPATING PLANS ONLY)

PRIMARY INSURANCE: _____

POLICYHOLDER'S NAME: _____ **DOB:** _____ **SSN:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

CLAIMS ADDRESS: _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

SECONDARY INSURANCE (ONLY IF WE PARTICIPATE): _____

POLICYHOLDER'S NAME: _____ **DOB:** _____ **SSN:** _____

POLICY NUMBER: _____ **GROUP NUMBER:** _____

CLAIMS ADDRESS: _____

RELATIONSHIP TO INSURED: SELF SPOUSE CHILD OTHER _____

REFERRAL/AUTHORIZATION INFORMATION

AUTHORIZATION #: _____ **CLINICIAN:** _____ **Number of Visits:** _____

Many insurance carriers require you to obtain a referral and/or authorization for mental health services. **The responsibility of obtaining a referral is that of the patient or the patient's guardian for your first appointment (only exception is Tricare).** Failure to get an initial authorization may result in non-payment from the insurance. **You will be responsible for any services denied by your insurance carrier due to not obtaining an initial authorization.** _____ **INITIAL**

Authorization for Assignment of Benefits / Release of Information/ Financial Agreement

I authorize the Northern Virginia Psychiatric Group (NoVaPsy) to apply for benefits from my insurance carrier and further authorize payment directly to NoVaPsy for the medical and/or mental health benefits, if any, otherwise payable to me for services rendered by NoVaPsy. I understand that this service is available for health plans that NoVaPsy participates and will only be submitted for the primary insurance plan unless my primary plan is Medicare. I further authorize the release of medical/mental health information required by my insurance carrier or its designated review agent, required for payment, or (if applicable) my employer’s worker’s compensation insurance carrier in order to determine benefits to which I may be entitled, or to designated agents of NoVaPsy. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me or by the insurance carrier at any time in writing. **I hereby assume financial responsibility for and agree to make payment in full to NoVaPsy for all charges for services provided to the above-named patient not otherwise authorized or paid by my insurance carrier.** Payment is to be made within fourteen (14) days as statements are presented with settlement in full, or payment arrangements to be made with NoVaPsy. I certify that the information given is true, accurate, and complete to the best of my knowledge, and further authorize NoVaPsy to investigate any and all information given concerning this or related claims

(Name Printed)

(Signature)

(Date)

Policies and Procedures

LATE CANCELLATIONS/ MISSED APPOINTMENTS POLICY:

If you cancel your appointment without 24 (twenty-four) hour notice, or do not show for a scheduled appointment, your clinician will charge you \$85 per session or \$55 for a med check appt. To avoid this charge, you must leave your clinician a message in their voice mail the preceding workday. All decisions concerning charges are made at the discretion of the clinicians. Our voice mail system records date and time of your call. Work-related cancellations are not excused cancellations and you will incur a charge.

FEES:

At the time of your visit, we will be glad to discuss our fee structure for specific diagnostic/treatment procedures. Please direct these questions to your clinician. You will be expected to pay your deductible and/or co-payment at the time of each visit. We will bill your primary insurance carrier if you have signed the authorization section above and we participate with health plan.

INSURANCE COVERAGE:

Insurance companies and employer plans vary significantly in how they administer mental health benefits. We strongly urge you to know what deductibles, co-payments, visit and/or benefit limitations, authorization requirements, and exclusions your plan may include. If we have submitted a claim to your carrier, we will receive an Explanation of Benefits (EOB) from the plan. NoVaPsy will use this information to determine your responsibility for full payment. You should review the EOB that is sent to you by the plan carefully. If you feel that they have made in error in administering your benefits, please call them directly to have it corrected. We will use the EOB as a final determination of benefits available.

NOTIFICATION OF CHANGES:

We expect that you will notify our office immediately of changes in the following information:

- Name, address, or phone number changes
- Change in Insurance Carrier
- Change in Primary Care Physician
- Change in marital status

RETURNED CHECKS:

There is a \$25 (Twenty-five) charge for any returned check from your bank.

PRESCRIPTION REFILLS: Refills not made during scheduled visits may be requested via email, fax, or phone. **If you choose to utilize our prescription refill service, you will be charged an administrative fee of \$20 that will not be billed to or reimbursed by your insurance carrier. Please refer to handout Medication Refills without a Visit for instructions. (attached for you to take with you).**

I understand and agree to abide by the above policies and procedures:

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

MEDICAL INFORMATION

1. Current Medications (name, dosage, start date) :

2. List Allergies:

3. List past and present medical problems:

4. List previous hospitalizations:

5. Do you smoke? _____ If yes, how many packs per day? ____ Years? _____

6. Do you drink alcohol/use drugs? ____ If yes, how often _____times per week
 Number of beers per week __ Cocktails __ Wine glasses __ Other(what)_____

7. Do you exercise? ____ If yes, how often? _____times per week
 What kind of exercise? _____

8. Does anyone in your family have the following? If yes, please describe:

Heart disease	Anxiety
Hypertension	Headaches
Strokes	Gynecological problems
Muscle problems	Urology problems
Joint problems	Thyroid problems
Gastrointestinal problems	Diabetes
Weight problems	Blood problems
Alcohol/ Drug Abuse	Cancer

9. Describe your present concerns. Be specific.

10. How did you learn about our center? _____

Northern Virginia Psychiatric Group, P.C.

PATIENTS' RIGHTS AND RESPONSIBILITIES STATEMENT:

Statement of Patient Rights:

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment. This is regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other member information kept private.
- Only in an emergency, or if required by law, can records be released without member permission.
- Patients have the right to information from staff/providers in a language they can understand.
- Patients have the right to have an easy to understand explanation of their condition and treatment.
- Patients have the right to know all about their treatment options, regardless of cost and whether that options are covered by insurance or not.
- Patients have the right to get information about NVPG's services and role in the treatment process.
- Patients have the right to relevant information about providers.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide input on NVPG policies and services.
- Patients have the right to know about the complaint, grievance and appeal process.
- Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process.
- Patients have the right to share in the formation of their plan of care.

Statement of Patients' Responsibilities:

- Patients have the responsibility to give providers information they need. This is so they can deliver the best possible care.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to follow their medication plan. They must tell their provider about medication changes, including medications given to them by other providers.
- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients should not take actions that could harm the lives of NVPG employees, providers, or other Patients.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to ask their providers questions about their care. This is so they can understand their care and their role in that care.
- Patients have the responsibility to let their provider know about problems with paying fees.
- Patients have the responsibility to follow the plans and instructions for their care. The care is to be agreed upon by the member and provider.

Signature

Name

Date

Confidentiality of Patient Records and Information

It is the policy of this office that:

1. All clinical records are protected from public viewing and access.
2. All clinical records are contained in individual file folders, identified by patient name.
3. All clinical records are kept in a locked filing cabinet or locked room.
4. Only office personnel authorized to access clinical records are given access to said files.
5. Clinical information will not be shared outside of Northern Virginia Psychiatric Group without the written consent of the client, except as required by law, or in a situation determined to be potentially life threatening.
6. All office personnel will be knowledgeable of the above and will follow all guidelines.

Northern Virginia Psychiatric Group, P.C.
Release of Information to Primary Care Physician

Your Primary Care Physician (PCP) with you has the responsibility for coordination of your total health care. In this endeavor PCPs often make referrals to other specialists for treatment of certain conditions. These physicians should receive information for their information and record as to medication and/or other services that are being provided to you. In this way, your Physician has access to all information relating to your health care and can make better-informed decisions regarding future care.

In this spirit, the Northern Virginia Psychiatric Group would like your authorization to provide certain information relating to diagnostic impressions, planned treatment course and any medications prescribed. This information would not include any personal information. To allow us to provide your primary care physician with this information, please complete the following:

I, _____ hereby authorize the Northern Virginia Psychiatric Group, P.C. to disclose the following information (clinical diagnosis, current or future treatment plans, and medications prescribed) to my primary care physician.

Dr. _____ at the following address:
(PCP first name) (PCP last name)

(street address)

(city) (state) (zip)

Signature of Patient/Parent Patient's name if signed by parent Date

I hereby decline the release of the above-mentioned information to my primary care physician.

Signature of Patient/Parent Patient's name if signed by parent Date

NORTHERN VIRGINIA PSYCHIATRIC GROUP, P.C.

Receipt Acknowledgement: Notice of Privacy

New Patient acknowledgement of the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations.

I have been provided with a *Notice of Privacy* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that NoVaPsy is not required to agree to the restrictions requested. I understand that I may revoke consent in writing, except to the extent that the organization has already take action in reliance thereon.

I further understand that NoVaPsy reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should NoVaPsy change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information: _____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I understand disclosure for these permitted uses, including disclosures via fax.

I acknowledge that I have been provided information regarding NOVAPSY's Privacy Provisions.

Patient's Signature

Patient/Guardian Name

Date

FOR OFFICE USE ONLY

Acknowledgement received by on .

Acknowledgement refused by patient, and treatment refused as permitted.

Acknowledgement added to the patient's medical record on _____.

REFILLS NEEDED ON NON-APPOINTMENT DAYS

There will be a \$20 charge for this service, which is not reimbursed by insurance AND due at the time of the request.

REFILL REQUESTS ARE ONLY PROCESSED MON-THURS BETWEEN 9AM-1PM AND IT MAY TAKE UP TO 48 HOURS TO PROCESS THE REQUEST.

REFILL LINE IS CLOSED ON FRIDAYS – ANY MESSAGE LEFT WILL BE PROCESSED THE FOLLOWING MONDAY.

INSTRUCTIONS ON HOW TO OBTAIN A REFILL ON NON-APPOINTMENT DAYS

YOU WILL NEED TO HAVE YOUR PHARMACY FAX US A REFILL REQUEST, our fax number is 703-573-2351. After having the pharmacy fax us a request, please call 703-698-5220 ext 602 at our office and leave your name, docs name and daytime number, credit card number, with expiration date and 3 –digit code on the back of the card and your refill will be processed. If we should have any questions, we will call you at the daytime number you provided us on the message.

If you are being prescribed a controlled medication (ADD medication) those cannot be called into the pharmacy and require an original prescription, you will need to leave a message on the prescription refill at 703-698-5220- *ext 602 OR* by sending an email to prescriptionrefill@nvpgpc.com and the leave the following information that is listed below.

INFORMATION YOU WILL NEED TO PROVIDE AT TIME OF EACH REQUEST

Doctor's Name
Patient's Name and DOB
Medication name and dosage
Date current prescription will run out
Daytime Telephone number (very important if there are any questions)

Delivery Preference:

- PICK UP prescription at NOVAPSY office. (Monday-Thursday 8:30 am -4:30pm, Fri until 3:30pm)
 - FEE due at time of pick up.
- OR**
- MAIL prescription: give current address and a credit card information and authorization to process \$20 fee. CREDIT CARDS require the 3-digit number on the back of the credit card to process. Credit card information needed to process below:
 1. TYPE OF CREDIT CARD: MasterCard VISA DISCOVER
 2. CREDIT CARD NUMBER
 3. NAME ON CREDIT CARD
 4. EXPIRATION DATE w/ 3-DIGIT CODE ON BACK OF CARD

MAIL ORDER SCRIPTS (90DAY SUPPLIES) MUST BE REQUESTED DURING YOUR APPOINTMENT.

WE WILL NOT FAX MAIL ORDER SCRIPTS TO YOUR MAIL ORDER COMPANIES.

YOU WILL NEED TO REQUEST RX FROM YOUR DOCTOR AND MAIL THEM IN DIRECTLY.