BEST LIFE
Mental Health & Wellness

PATIENT REGISTRATION INFORMATION

Name: ____ DOB: ____________________ Gender: __________

Address:

____

City:_____________________________________ State: ____________________Zip:____________________

Mobile Phone: _____________________________________Other Phone: _____________________________________

SSN: ____ E-mail: ____

RelaPonship Status: Single: _____ Married: _____ Partner: ______ Divorced: ______ Widowed: ______ Legal Guardian:

____

EMERGENCY CONTACT

Who should we contact in case of an emergency?

____

RelaPonship: _______________________________ Contact #: ____

REFERRAL / MEDICAL INFORMATION

How did you hear about our pracPce?

____

Primary Care Provider/Pediatrician: ____

Phone # ______________________________________Fax # ______________________________________

Preferred Pharmacy: ____

Address: ____Phone #______________________________________

Current medicaPon: ____

INSURANCE INFORMATION

PRIMARY

Insurance company: _________________________________Subscriber Name:____________________________________

Subscriber DOB:________________________________Subscriber ID:____________________________________

Insurance Start Date:______________________________ RelaPonship: ____________________________________

Pa)ent Signature or Legal Representa)ve: ____

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Date:

____________________________RelaPonship: ____

CONSENT FOR TREATMENT

I, the paPent or paPent's legal representaPve, hereby authorize permission to providers of Best Life Mental Health & Wellness PLLC, to perform such examinaPons, medical, and therapeuPc procedures as may be professionally deemed necessary or advisable and to communicate about them via telepsychiatry, telephone, mail, fax, and e-mail for my/ the paPent's diagnosis, treatment, payment, and healthcare operaPons. I am aware that the pracPce of medicine is not an exact science and that no guarantees or promises have been made to me as to the result of treatment or examinaPon, and that iniPal consultaPon does not necessarily create a doctor-paPent relaPonship. I consent for Best Life Mental Health & Wellness PLLC, to obtain my prescripPon history.

Pa)ent Signature: ____Date: __________________________ If

the paPent is a minor or unable to sign, authorizaPon is given on the paPent's behalf:

Signature: ____ Date: ___________________________

Printed Name: ____RelaPonship to paPent: _________________________

COMPLIANCE ASSURANCE NOTIFICATION

All health professionals and office staff conPnuously undergo training so that they may understand and comply with government rules and regulaPon regarding the Health Insurance Portability and Accountability Act (HIPAA) with parPcular emphasis on the "Privacy Rule" We strive to achieve the highest standards of ethics and integrity in performing services for our paPents. Our policy is to correctly determine appropriate uses of Personal Health InformaPon (PHI) in accordance with HIPAA. We are required by law to maintain the privacy of, and provide individuals with this noPce of our legal duPes and privacy pracPces with respect to PHI. We want to ensure our paPents that our pracPce will not knowingly contribute in any way to the growing problem of improper disclosure on PHI. Any quesPons regarding this policy may be directed to the Office Manager.

NOTICE OF PRIVACY PRACTICE RIGHTS (HIPPA)

I, ____ , acknowledge that I have read and understand the NoPce of Privacy PracPces provided by Best Life Mental Health & Wellness

Signature of Pa.ent (or Legal Guardian): ____ **Date:**

____

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PATIENTS RIGHTS AND RESPONSIBILITIES

If you currently are or have been a paPent of mental health services, you have the right to the following:

- Access services that are appropriate to your disability, culture, language, gender, and age.
- Be treated with respect and with due consideraPon of your dignity and privacy.
- Receive informaPon on available treatment opPons and alternaPves, present in a manner appropriate to your condiPon and ability to understand.
- ParPcipate in decisions regarding your health care, including the right to refuse treatment.
- Be free from any form of restraint or seclusion used as a means of discipline or retaliaPon. ● An individual treatment plan to ensure the quality of care and coordinaPon of care.

I acknowledge the above informaPon and my paPent rights and responsibiliPes. A copy of the paPent's rights and the consumer handbook for mental health from the NC Department of Health and Human Services is available to me from Best Life Mental Health & Wellness by request.

Signature of Pa)ent (or Legal Guardian): ____ ***Date:***

____

PATIENT PAYMENT AND BALANCES

All services are payable at Pme of your appointment. We can reschedule you if unable to pay at the Pme of your appointment. Please feel free to speak with the staff regarding prices, balances, or any other quesPons regarding payments.

SELF PAY FEE SCHEDULE/ POLICY

Self-pay rates are as followed:

Ini)al/new evalua)ons: 60-minute appointment = $300

***Follow*-up visits**: 20-30 minutes appointment = $115

3- month Follow-up visits: 30-minute appointment = $135

DIRECT PAY FOR MENTAL HEALTH SERVICE (DPMHS):

Ini)al Visit: 40 to 60-minute appointment = $300

Follow-up Visits: 20- 30-minute appointment = $105 automaPc monthly payment *(can be canceled at any,me)*

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FULL
TELEPSYCHIATRY (NO IN-OFFICE VISITS)

The payments for telepsychiatry will be taken via debit or credit card at the Pme of the appointment. We are an "out of network provider" and do not accept insurance for telepsychiatry appointments at this Pme. If interested in telepsychiatry services, please ask to complete the **telepsychiatry form**. Telepsychiatry will not be available to paPents taking benzodiazepines, substance abuse, or paPents with borderline personality disorder due to requiring more in office care.

FEE FOR TELEPSYCHIATRY

Initial Visit: 60 minute appointment = $250

Follow-up Visits: 20-30 minute appointment = $135

3- month Follow-up visits: 30-minute appointment = $155

NO SHOWS

PaPents will be charged a **$65-dollar fee for any no-show without a prior 24-hour cancella.on** for any service scheduled. The paPent will be provided with one documented excuse for missing their appointment. The no-show fee must be collected prior to the paPent re-scheduling a new appointment.

WE DO NOT ACCEPT OR COMPLETE WORKER'S COMPENSATION CLAIMS, FAMILY AND MEDICAL LEAVE ACT (FMLA), DISABILITY FORMS, SERVICE DOGS, OR PERMISSION FOR BARIATRIC PROCEDURES.

REFUNDS WILL ONLY BE PROVIDED IF SERVICE WAS NOT RENDERED FOR PATIENT.

POLICY FOR MEDICATION REFILLS

If a paPent needs a medicaPon refill for ***non-controlled medica)ons***, but has missed their previous appointment, a onePme courtesy medicaPon refill can be made within a 6-month period. In order for the refill to be sent, the paPent is required to schedule a follow-up visit. This paPent will be responsible for a $35 charge at this Pme.

All paPents needing a refill for ***controlled medica)ons*** (benzodiazepines, sleep medicaPons, and sPmulants) are required to have a scheduled appointment.

FOR ADDITIONAL PATIENT REQUESTS <u>NOT</u> INCLUDING: OUTSIDE OF SCHOOL/WORK NOTES, OR SCHOOL NURSE MEDICATION PRESCRIPTION FORMS WILL BE AN ADDITIONAL $15 FEE.

Please note that prac)ce policies, procedures, regula)ons, and fees located in this packet are subject to change at any)me.

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CONTROLLED SUBSTANCE AGREEMENT

In the event that my treatment requires the use of controlled substance(s) I adhere to the following agreement:

- I am making this agreement while in **complete possession of my facul.es and** not under the influence of any substances that might impair my judgement.
- I will noPfy my medical provider on any new health concerns I have even if not related to my treatment.
- I will not obtain any controlled medicaPons for another medical provider with out informing this pracPce of the circumstances involved. This includes pain pills, muscle relaxers, anP-anxiety, or sPmulants medicaPons.
- I will not be involved in the sale, transport, or sharing on any controlled substance or medicaPon.
- I will safeguard my medicaPon from theq or loss. I will carry only the amount of medicaPon needed in the correct prescripPon container for the Pme that I am away from home. The remaining medicaPon will be kept in a safe place.
- I will not ask for early refills, this includes lost, stolen, wet, burned, or etc.
- I will follow the direcPon that is wriren on the prescripPon container. I will not take more frequent or larger doses.
- In the event that I am arrested or incarcerated related to legal or illegal drugs, I will not be given any refills of controlled substances. I understand that my involvement in such acPvites could result in terminaPon of care from Best Life Mental Health & Wellness.
- If I am a female, I understand that if I become pregnant, or if I am suspicious that I am pregnant, I will noPfy my provider immediately.
- I agree to use only one pharmacy for obtaining controlled substance medicaPons. I am to noPfy my provider if I wish to change pharmacies and this must be done prior to requesPng refills and/or at Pme of appointment.

I have read this document and agree to the guidelines. If I had difficulty understanding the content, I have asked for clarificaPon. If my prescripPon (s) is/are not helping to improve my life, I will report this to my provider. I understand that if this agreement is not followed, I may be discharged from this pracPce.

Pa)ent Name Printed:____

Pa)ent Signature: ____

URINE DRUG SCREEN (UDS)

Why do I need to provide a urine sample?

For your health and safety, our pa,ents at Best Life Mental Health & Wellness, PLLC are requested to provide urine samples to comply with the suggested federal guideline. By monitoring urine samples at Best Life Mental Health & Wellness, PLLC the company can evaluate the following:

- *Understand the precise levels of drugs in each pa,ent*
- *Iden,fy dangerous drug to drug interac,on*
- *Monitor compliance with prescribed medica,ons and treatment plans*

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How o^en will I have to leave a urine sample?

Best Life Mental Health & Wellness PLLC strives to follow proper protocols according to the federal guidelines that require providers to limit possible drug diversion. New paPents and the paPents on any controlled substance will be requested to leave a UDS or obtain a UDS from their preferred lab company prior to receiving controlled substances. PaPents who conPnue to maintain on a controlled substance will be required to repeat UDS every three months or upon the provider's request.

Who will see the results?

Our office staff and lab personnel are authorized to view your lab results. Best Life Mental Health & Wellness PLLC UDS policy enforces that paPents will not receive refills on controlled medicaPons or be prescribed a controlled medicaPon if the paPent fails the urine drug screen or have a prior history of substance abuse. We will be able to assist in alternaPve medicaPons to treat paPents.

_______ ***I consent to provide a Urine Drug Screen.***

_______ ***I do not consent to Urine Screen. By checking this op)on, I will not receive any controlled medica)ons.***

Name of Pa)ent (please Print): ____

Signature: ____***Date:***________________________________

PATIENT SERVICE AGREEMENT

Welcome to Best Life Mental Health & Wellness, we are honored that you have chosen us as your mental health provider and look forward to working with you. The mental health system can be confusing, and we expect that you may have quesPons regarding our services. We hope that this document will answer your quesPons. This PaPent Service Agreement contains important informaPon about the services that we provide and your rights and responsibiliPes while undergoing treatment. It is very important that you read this agreement carefully. By signing this agreement, you are entering into a binding agreement with Best Life Mental Health & Wellness. We can discuss any quesPons you have about this agreement or our office procedures upon your request.

_______Please iniPal that you have read, understand and agree to the above described appointment cancellaPon, rescheduling, and no show agreement.

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MEDICAL EMERGENCY:

If paPent is experiencing a life threatening emergency, worsening symptoms, suicidal ideaPon, or severe reacPons to medicaPon, please call 911 and go directly to the Emergency Room. If the police need to be involved, request for the Crisis IntervenPon Team (CIT) for officers trained in mental health crises. For all other mental health crises, contact HOPE4NC: 1.855.587.3463 or text “hope” to 1.855.587.3463.

Hospitals located in this area:

Lake Norman Regional Medical Center: 704.660.4000

Davis Regional Medical Center: 704.873.0281

Novant Health Huntersville Medical Center: 704.316.4000

Atrium Health Huntersville: 704.512.3100

INAPPROPRIATE BEHAVIOR WILL NOT BE TOLERATED AND WILL LEAD TO AUTOMATIC DISCHARGE FROM THE PRACTICE. THIS MAY INCLUDE AGGRESSIVE BEHAVIOR, CURSING, OR NON-COMPLIANCE WITH TREATMENT.

TERMINATION

PaPent reserves the right to terminate services with Best Life Mental Health & Wellness at anyPme. We request that paPent noPfies the office if paPent relocates or leaves the services of Best Life Mental Health & Wellness. This will ensure us that you will be receiving care elsewhere and/or we can refer you to other mental health professionals to help you with your needs if necessary. If there is a complaint pertaining to Best Life Mental Health & Wellness please contact our office manager to resolve the issue. If you decide to stop treatment with Best Life Mental Health & Wellness, you are responsible for any previous fees already acquired. Best Life Mental Health & Wellness also reserves the right to terminate services with any paPent due to the following circumstance but not limited to: **AGGRESSIVE BEHAVIOR, CURSING, THREE OR MORE CALLS IN 24 HOURS, OR NON-COMPLIANCE WITH TREATMENT.**

INAPPROPRIATE BEHAVIOR WILL NOT BE TOLERATED AND WILL LEAD TO AUTOMATIC DISCHARGE FROM THE PRACTICE.

Signature: ____**Date:** _______________________