



# BEST LIFE

## Mental Health & Wellness

### ***PATIENT REGISTRATION INFORMATION***

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mobile Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

SSN: \_\_\_\_\_ E-mail: \_\_\_\_\_

Relationship Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_ Partner: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_

Legal Guardian: \_\_\_\_\_

***SELECT CONTACT METHOD FOR APPOINTMENTS & REMINDERS:*** Text: \_\_\_ Voicemail: \_\_\_ Email: \_\_\_ All: \_\_\_

### ***EMERGENCY CONTACT***

Who should we contact in case of an emergency? \_\_\_\_\_

Relationship: \_\_\_\_\_ Contact #: \_\_\_\_\_

### ***REFERRAL / MEDICAL INFORMATION***

How did you hear about our practice?  
\_\_\_\_\_

Primary Care Provider/Pediatrician: \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

### ***INSURANCE INFORMATION***

#### ***PRIMARY***

Insurance company: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Subscriber DOB: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Insurance Start Date: (month, year) \_\_\_\_\_ Insurance End Date: (month, year): \_\_\_\_\_

Relationship: \_\_\_\_\_

***Patient Signature or Legal Representative:*** \_\_\_\_\_

Date: \_\_\_\_\_ Relationship: \_\_\_\_\_



**BEST LIFE**

Mental Health & Wellness

**CONSENT FOR TREATMENT**

I, the patient or patient’s legal representative, hereby authorize permission to providers of Best Life Mental Health & Wellness PLLC, to perform such examinations, medical, and therapeutic 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 patient's diagnosis, treatment, payment, and healthcare operations. I am aware that the practice 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 examination, and that initial consultation does not necessarily create a doctor-patient relationship. I consent for Best Life Mental Health & Wellness PLLC, to obtain my prescription history.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ **If**

the patient is a minor or unable to sign, authorization is given on the patient’s behalf:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Relationship to patient:** \_\_\_\_\_

**COMPLIANCE ASSURANCE NOTIFICATION**

All health professionals and office staff continuously undergo training so that they may understand and comply with government rules and regulation regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the “Privacy Rule” We strive to achieve the highest standards of ethics and integrity in performing services for our patients. Our policy is to correctly determine appropriate uses of Personal Health Information (PHI) in accordance with HIPAA. We are required by law to maintain the privacy of, and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. We want to ensure our patients that our practice will not knowingly contribute in any way to the growing problem of improper disclosure on PHI. Any questions 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 Notice of Privacy Practices provided by Best Life Mental Health & Wellness

**Signature of Patient ( or Legal Guardian):** \_\_\_\_\_ **Date:**

\_\_\_\_\_



# **BEST LIFE**

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### ***PATIENTS RIGHTS AND RESPONSIBILITIES***

If you currently are or have been a patient 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 consideration of your dignity and privacy.
- Receive information on available treatment options and alternatives, present in a manner appropriate to your condition and ability to understand.
- Participate 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 retaliation. ● An individual treatment plan to ensure the quality of care and coordination of care.

I acknowledge the above information and my patient rights and responsibilities. A copy of the patient'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 Patient ( or Legal Guardian):*** \_\_\_\_\_ ***Date:***

### ***PATIENT PAYMENT AND BALANCES***

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

#### ***SELF PAY FEE SCHEDULE/ POLICY***

Self-pay rates are as followed:

***Initial/new evaluations:*** 40-minute appointment = \$300

***Follow-up visits:*** 30-minute appointment = \$135

#### ***DIRECT PAY FOR MENTAL HEALTH SERVICE (DPMHS):***

***Initial Visit:*** 40 to 60-minute appointment = \$300

***Follow-up Visits:*** 20-minute appointment = \$105 automatic monthly payment (*can be cancelled at anytime*)



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### ***FULL TELEPSYCHIATRY (NO IN-OFFICE VISITS)***

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

### ***FEE FOR TELEPSYCHIATRY***

***Initial Visit:*** 40-minute appointment = \$250

***Follow-up Visits:*** 20-minute appointment = \$125

### ***NO SHOWS***

Patients will be charged a **\$65-dollar fee for any no-show without a prior 24-hour cancellation** for any service scheduled. The patient will be provided with one documented excuse for missing their appointment. The no-show fee must be collected prior to the patient 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 patient needs a medication refill for ***non-controlled medications***, but has missed their previous appointment, a onetime courtesy medication refill can be made within a 6-month period. In order for the refill to be sent, the patient is required to schedule a follow-up visit. This patient will be responsible for a \$35 charge at this time.

All patients needing a refill for ***controlled medications*** (benzodiazepines, sleep medications, and stimulants) are required to have a scheduled appointment.

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

***Please note that practice policies, procedures, regulations, and fees located in this packet are subject to change at any time.***



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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 faculties and** not under the influence of any substances that might impair my judgement.
- I will notify my medical provider on any new health concerns I have even if not related to my treatment.
- I will not obtain any controlled medications for another medical provider with out informing this practice of the circumstances involved. This includes pain pills, muscle relaxers, anti-anxiety, or stimulants medications.
- I will not be involved in the sale, transport, or sharing on any controlled substance or medication.
- I will safeguard my medication from theft or loss. I will carry only the amount of medication needed in the correct prescription container for the time that I am away from home. The remaining medication 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 direction that is written on the prescription 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 activites could result in termination 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 notify my provider immediately.
- I agree to use only one pharmacy for obtaining controlled substance medications. I am to notify my provider if I wish to change pharmacies and this must be done prior to requesting refills and/or at time of appointment.

I have read this document and agree to the guidelines. If I had difficulty understanding the content, I have asked for clarification. If my prescription (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 practice.

**Patient Name Printed:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_

### **URINE DRUG SCREEN (UDS)**

#### **Why do I need to provide a urine sample?**

*For your health and safety, our patients 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 patient*
- *Identify dangerous drug to drug interaction*
- *Monitor compliance with prescribed medications and treatment plans*



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***How often 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 patients and the patients 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. Patients who continue 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 patients will not receive refills on controlled medications or be prescribed a controlled medication if the patient fails the urine drug screen or have a prior history of substance abuse. We will be able to assist in alternative medications to treat patients.

\_\_\_\_\_ ***I consent to provide a Urine Drug Screen.***

\_\_\_\_\_ ***I do not consent to Urine Screen. By checking this option, I will not receive any controlled medications.***

***Name of Patient (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 questions regarding our services. We hope that this document will answer your questions. This Patient Service Agreement contains important information about the services that we provide and your rights and responsibilities 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 questions you have about this agreement or our office procedures upon your request.

\_\_\_\_\_ Please initial that you have read, understand and agree to the above described appointment cancellation, rescheduling, and no show agreement.

Office is currently under ring security surveillance for the safety of all patients and staff.



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### ***MEDICAL EMERGENCY:***

If patient is experiencing a life threatening emergency, worsening symptoms, suicidal ideation, or severe reactions to medication, please call 911 and go directly to the Emergency Room. If the police need to be involved, request for the Crisis Intervention 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***

Patient reserves the right to terminate services with Best Life Mental Health & Wellness at anytime. We request that patient notifies the office if patient 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 patient 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:** \_\_\_\_\_