THE MIND & BODY CONSORTIUM
Furthering your ability to Live Well!

156 S. State Street Dover, DE 19901
513 N. DuPont Blvd. Milford, DE 19963
118 Sandhill Drive, Suite 200 Middletown, DE 19709
900 Foulk Road, Suite 200 Wilmington Delaware 19803
Phone: 302-674-2380 Fax: 302-674-1299

Patient Information Form

Last Name: _____ First Name: _____ M.I._____

Address: _____

City, State, Zip: _____

Social Security Number _____ Date of Birth: _____Age:_____

Marital Status:_____ Race:_____ Are you Latino/Hispanic:

Do you have any of the special needs listed: Hearing Impairments:

Need a translator: Do you use a wheel chair? Legally Blind:

Phone Number(s): Primary Number:_____2ndary Number:_____

May we leave messages at the phone numbers provided above?:

Or Special Message Instructions:_____

EMAIL ADDRESS FOR TELEHEALTH SESSIONS:_____

(This format is only supported during the COVID-19 crisis and may be subject to change)

If patient is a minor, name of Guardian: _____

Guardians Address (if not same as above)_____

Guardians Date of Birth:_____Social Security Number:_____

Relationship to Patient:_____ Employer:_____

If patient is a minor, name of Guardian: _____

Guardians Address (if not same as above)_____

Guardians Date of Birth:_____Social Security Number:_____

Relationship to Patient:_____ Employer:_____

Emergency Contact Person, Name and Phone Number (if above Guardian cannot be contacted): _____

Relationship:_____

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Billing and Insurance Information:

You are responsible for accurately listing the Primary, Secondary and Tertiary Insurance Carriers, and knowing your mental health benefits and yearly visit limitations.

Insurance Company Responsible for Payment. List Primary Carrier Below:

Ins Company: _____ ID#: _____

Group #: _____

Policy Holder: _____ DOB: _____ Employer:_____

Policy Holder Address_____

Insurance Company Phone Number and Address: Policy Holders Social Security Number:

_____ _____

_____

Secondary Insurance: Ins Company: _____

ID#: _____Group # _____

Policy Holder: _____ DOB: _____ Employer: _____

Insurance Company Phone Number and Address: _____

_____

Insurance Authorization and Assignment: I attest that I have provided complete and accurate information regarding insurance coverage for myself (and/or minor child client). I understand that I am financially responsible for any sessions not authorized, denied or left unpaid by my insurance carrier. I authorize the release of any medical, mental health, or substance abuse information necessary to process insurance claims for the duration of my treatment. I also request payment of benefits directly to The Mind and Body Consortium, LLC for the services described and submitted on the claim form(s).This authorization is for the duration of my treatment and until all claims are submitted and processed. I understand that I am responsible for any deductible, co-insurance, co-pay amounts. I am **responsible to provide any changes in insurance within twenty (20) days of the new effective date** to The Mind and Body Consortium.LLC.

Signature: _____ **Date:** _____

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Authorization to Disclose Information to Primary Care Physician

Report to Primary Care Physician From Mind & Body Consortium LLC

The patient named below has consented to allow me to communicate with you about their treatment.

I understand that my records are protected under the applicable state law(s) governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this
consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months following the termination of treatment services at The Mind & Body Consortium LLC

I,_____ hereby authorize the Staff of The Mind & Body Consortium, LLC
(Please print client/guardian name)

Please check all that Apply:

☐ to release any applicable information to my Primary Care Physician

☐ to obtain any applicable information to my Primary Care Physician

_____
Signature of client or Parent/Guardian

_____
_____
Please print the name signed above
Date _____

Primary Care Physician's Name, Address, and Phone Number, Fax Number:

_____
_____ _____

Preferred Pharmacy – Location, Phone Number, Fax Number:

_____
_____

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Patient Information Form Acknowledgements and Contract

Mind & Body Consortium, LLC wishes to ensure that all clients have enough information regarding the agency and the treatment in which they are participating to make informed decisions. Please read the following pages carefully as your signature verifies that you have received various documents, understanding of expectations regarding your participation, and Knowledge of agency policies. If you have not received the information listed, please request it or ask for any needed clarification prior to signing.

Private Health Information

Health information which we receive and/or create about you, personally, in this program, relating to your past, present or future health, treatment, or payment for health care services, is "protected health information" under the Federal law known as the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 and 164.

The confidentiality of alcohol and drug abuse patient records maintained by this program is protected by another Federal Law as well, commonly referred to as the Alcohol and Other Drug (AOD) Confidentiality Law, 42 C.F.R. Part 2. Generally the program may not say to a person outside the program that you attend the program, or disclose any information identifying you as an alcohol or drug abuser, or use or disclose any other protected health information except in limited circumstances as permitted by Federal Law. Your health information is further protected by any pertinent state law that is more protective or stringent than either of these two Federal laws.

All new clients receive the "Notice of Privacy Practices" which describes how we protect personal health information we have about you, and how we may use and disclose this information. The notice also describes your rights with respect to protected health information and how you can exercise those rights.

Mind & Body Consortium Outpatient Services Admission and Discharge Criteria

Admission Criteria

1. Client has an identifiable behavioral health problem with an Axis I Diagnosis.
2. Client does not meet criteria for a more or less restrictive Level of Care.
3. Face-to-face participation is necessary and sessions last at least 45 minutes. (Medication management sessions may be shorter.)
4. Program Staff is qualified/able to adequately treat the client's unique presenting problems.

Continued Treatment

1. Client continues to meet admission criteria.
2. A problem-focused, goal-oriented treatment plan is formulated.
3. The involvement of family in child/adolescent treatment is required unless precluded by legal restrictions.
4. Evidence of compliance with treatment program and motivation for treatment is indicated.

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Discharge Criteria

1. The client/family has met the goals identified at intake and developed during the course of treatment.
2. Client/family terminates treatment at their own discretion.
3. A higher or lower level of care is needed therefore requiring a referral to internal or external programming.
4. A patient can be discharged for non-compliance (which includes being verbally abusive to staff, damaging physical property, late cancellations, multiple no shows, aggressive behavior towards staff, failure to disclose substance abuse, and/or refusing to follow treatment recommendations).

Medication Treatment

When your Psychiatrist or Nurse Practitioner prescribes you or your family members a new medication or new dosage of an existing medication he/she will review the possible adverse side effects, the benefit of the medication, possible interactions, and possible consequences of not taking the medication or not taking the medication as prescribed. While every effort is made to educate the client regarding the effects of prescribed medication, it is also an expectation that all clients and/or guardians will seek further information as needed to allow them to make an informed decision regarding their medication usage. It is expected that all clients will read all information that comes with their medication, and request from their pharmacists any literature available regarding the medications they are taking and possible interactions with other medications. Clients should also alert their Primary Care Physician of all medication changes. Additionally, clients may request copies of medication information available in the Physicians' Desk Reference. It is the patient guardian's responsibility to report any medication that is being taken by the client at his/her time of admission and any changes throughout treatment. Any side effects must be reported immediately. Clients and guardians do reserve the right to refuse medication management and continue with outpatient behavioral health treatment**. Any rewrites due to lost or misplaced prescriptions are subject to a $15.00 rewrite fee** **Initial Here: _____**

Confidentiality

I understand that information between myself and provider is held strictly confidential and my therapist will not release any information about my therapy unless permitted by law or: (1) I agree in writing to permit such a release. (2) My therapist believes I pose a physical danger to myself (3) My therapist believes I pose a danger to others, (4) Child/elder abuse/neglect is suspected. I understand that in the latter 2 cases, the therapist is required by law to inform potential victims and legal authorities so that protective measures can be taken. If I participate in group counseling, I agree to not discuss any details of the group outside of the counseling sessions.

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Release of Information
In addition to releases of information permitted above, I further authorize the release of information for claims, certification/case management/quality improvement and other purposes related to the benefits of my health Plan. [Releases of information to providers, family, etc, require separate form(s).] Please request additional releases from your provider and/or office staff.

Appointment Reminder Calls and Calls Pertaining to Prescription Medication/Usage
Mind & Body Consortium, LLC typically makes courtesy calls to a client's home or designated primary number one day prior to the scheduled appointment. Reminder information typically includes the time and date of the appointment, name of the clinician, company and any balance that may need to be paid prior to treatment. Return calls may also be provided from the Patient Care Coordinator or designee. These calls are medical in nature and may contain medication information to include medication name(s), dosing instructions, redirection if misuse has occurred or is suspected. The information is also left on the home answering machine or voice mail if one picks up the call. Clients who do not want these calls or have a specific request regarding how these calls are made should note special instructions below. We will do our best to accommodate any request but do not guarantee all requests can be accommodated. You are responsible to update your personal information as you see fit.
Special Request: _____

Cancelled/Missed Appointments
If an appointment is **missed or cancelled with less than 24 hours notice**, the account will be **charged forty dollars ($40)** and this fee **must be paid prior** to the next appointment. Clients missing two appointments in a row or repeated no shows in the course of treatment, as subject by the clinician, the patient will be terminated from services at Mind & Body Consortium LLC. Please be advised that no show charges are also charged to an account based upon contractual obligations with your insurance company. **Group Therapy** sessions are subject to a $15.00 missed session fee. **Initial Here: _____**

Financial Terms
Payment is to be made in full with cash, personal check, or credit card at the time of the session. For those plans which Mind & Body Consortium, LLC accepts assignment upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for you and the company and/or Provider will be paid directly by the carrier. You will be responsible for any applicable deductibles, co-payments, and co-insurance payments. By consenting for treatment you agree to make these payments at each appointment. You further understand that if you are not eligible at the time services are rendered, you are responsible for payment, even if the determination is made after services are rendered. All fees are due within forty-five (45) days of the date of service. Fees not paid within this time frame are subject to be forwarded to collections. Any account forwarded to collections or another outside collection agency will be subject to up to a 36.5% fee of the balance due. The client or guardian is responsible to notify the billing department of any/all insurance changes. You must report insurance changes within twenty (20) days of the effective changes. Any changes not reported in a timely manner will render the client and/or guardian responsible for services. Return checks are subject to at $40.00 fee. Services may be suspended for unpaid accounts. **Initial Here: _____**

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Legal Time/Services/Court Appearances
Legal time is billed separately and will not be billed to your insurance company. Legal time, appearances, whether requested by the client or under subpoena will be billed to the petitioning party and/or at the direction of the lawyers involved. Legal fees must be paid within (7) seven days of the services being rendered. Legal fees are set by each clinician and/or physician and any inquiries about fee schedules should be directed to the billing department or office manager.

Records Fees
Records fees are billable to the patient or requesting party. Records fees must be paid in advance. Records fees includes search and retrieval fees, completion of paperwork to include, but not limited too, Disability Forms, Transportation Forms, Housing and Benefits forms, Etc.) Records Fees are posted and are subject to change without notice. Any question regarding records are directed to the Records Technician. MBC does not release records directly to patients. In lieu of treatment records, MBC can supply summary documentation (fees will apply). Please be advised that request for records can take up to twenty-one (21) days and may require additional sessions with the requested practitioner so that we can complete forms accurately.

Determination of Insurance Benefits
When you become a patient at Mind and Body, we attempt to contact your insurance company to obtain information regarding your coverage for mental health care. Unfortunately, this verification of benefits does not oblige insurers to pay. Insurance companies protect themselves by stating that verification of insurance coverage by them is:

- Not a guarantee of payment, and is
- Not a guarantee of what is actually covered and not covered.

Because of this disclaimer, even when told that a service is covered, there is no obligation for them to pay. The true determination as to whether a service is covered is made at the time the claim is received by the insurance company. Whether insurance will pay is dependent on whether:

- The service received is covered by your plan
- The reason for the service (the diagnosis) is covered by your plan
- The appropriate deductibles and co-pays have been met
- “Pre-existing conditions” exclusions apply

It is very important for you to understand that the only TRUE representation of whether a given service is covered is when your insurance company actually processes the claim. You as the recipient of the service, or parent/guardian of the minor receiving services, must know what company processes your mental health benefits. This is information must be relayed to our facility. Additionally, insurance companies routinely perform audits of claims. If it is determined that a claim was paid in error a retraction will be issued to your insurance carrier. If this should occur we will then contact you for payment of these services. Insurance audits can be performed several years after claims payments.

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Settling of Balances

As discussed above, there are times when insurance companies process a claim in a manner different than expected. In these cases:

Initial Each Box	
	A claim may be completely denied as not covered, with no payment being made, thereby making you entirely responsible for the charge.
	A claim may pay differently than was anticipated, thereby making you responsible for a larger portion of the charge than expected.
	Even though your insurance company communicated to us a service or set of services is covered, with or without authorization, they may deny coverage and thus payment of the service. This makes your entirely responsible for the service or set of services.

Credit Card Authorization

Effective, May 15, 2018, clients who have a commercial payor on file must place a credit card on file prior to services being rendered. Please refer to separate form “Credit Card Authorization”.

Consent for Treatment

I further authorize and request that my therapist carry out psychological or psychiatric examinations, treatments, and/or diagnostics procedures which now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

If you consent for treatment please sign.

Patient/Guardian Signature: _____

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Patient Rights and Responsibilities

Part 1:The Rights of the Patient

1. You have the right to be treated with respect and dignity and receive quality services.
2. You have the right to have your clinical information kept confidential within the constraints of the law.
3. You have the right to an explanation of your conditions of treatment.
4. You have the right to participate in decisions involving your treatment. You may refuse treatment at any time.
5. You have the right to refuse to participate in scientific research. This type of refusal will not omit you from your regular course of treatment in any way.
6. You have the right to have your complaints heard.
7. You have the right to request a male or female therapist, as well as a therapist who understands and speaks your language. We will try to honor these requests so long as we have available staff.
8. You have the right to request a change in therapist. We will try to accommodate such requests. Such a request will be void if you have been terminated from the practice or are pending possible termination.
9. You have the right to receive assistance with respect to knowing and understanding your mental health and substance abuse benefits.
10. You will not be discriminated against based on race, religion, gender, gender identity, gender expression, sexual orientation, familiar status, or disability.

Part 2: The Responsibilities of the Patient

1. You are expected to support the patient therapist relationship. For example, you should exercise courtesy and make every effort to keep scheduled appointments. A "no show" payment will be applied if you miss an appointment without notifying the office. Notification must be made at least 24 hours in advance on your scheduled appointment.
2. You are expected to present true and accurate information when it is requested and participate actively in planning of your treatment.
3. You are expected to follow the recommendations of the clinical treatment program and address any problems about your treatment with your provider.
4. You may not use profane language, threaten or endanger the life, health, or social well-being of any staff members or another, individual in our premises.
5. You may not engage in any illegal acts, such as altering or forging a staff members name (to include prescriptions, work/school excusals, disability forms, housing forms, etc).
6. You are expected to pay any necessary fees at the time of your appointment.
7. You are expected to notify your therapist or the office manager if you are terminating treatment.
8. You are expected to respect the confidentiality of other patients or visitors you may encounter on our premises.
9. Timeliness: If you are more **than fifteen (15) minutes late for a 60 minute appointment** we reserve the right to reschedule you**.** ***All*** *appointments scheduled for 15-45 minutes in duration* ***may be rescheduled*** *if the patient is* ***NOT*** *on time.* **With very little exception do we take medication clients late.**

Please sign stating that you agree and understand these terms:

Patient/Guardian Signature_____ **Date:** _____

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Complaints/Feedback

Feedback, either positive or negative, regarding our services and staff is always appreciated. You have the right to file a complaint about any and all services provided and to receive feedback in a reasonable amount of time. We encourage you to discuss any complaints with your provider(s). You may however contact the CEO/Owner/M.B.A., Lisa Leidy to file a complaint or give feedback. If you provide a written complaint an outcome of an investigation will be mailed to the return address indicated in that notice.

I, the patient or guardian for the patient, have read the materials presented in this disclosure statement. My signature indicated that I understand the information presented in this packet and all my questions have been answered to my satisfaction. I agree with the conditions of therapy that are either stated or implied here and commit myself to compliance with them. I also agree that my provider(s) may discuss information regarding my case with another covering provider in my provider(s) absence. I also understand that I have the right to NOT sign this form until I discuss my concerns with my provider before treatment begins. I understand that once mental health treatment begins I have the right to withdraw my consent to participate in treatment at any time that seems appropriate. I will make every effort to discuss my concerns about progress of my treatment with my provider(s). My rights as a patient or guardian of a patient, which includes my right to review records, have been explained to me. Additionally, I have received a copy of the agency's privacy practices and copies of any signed releases I have requested.

_____

Signature of Patient and Date

_____

Signature of Parent/Guardian (if patient is a minor or other extenuating circumstance) and Date

_____

Signature of Staff as Witness and Date