Patient Account Number: _____

THE PISGAH INSTITUTE FOR PSYCHOTHERAPY AND EDUCATION, P.A.

DOCTOR/CLINICIAN YOU WILL BE SEEING: _____ DATE BEING SEEN: _____

PATIENT INFORMATION

NAME _____
LAST FIRST MIDDLE PREFERRED NAME and/or PRONOUNS

DATE OF BIRTH: _____ S.S.N._____

GENDER PER YOUR INSURANCE: ☐ Female ☐ Male

If different gender identity, please specify: ☐Transgender male(female to male) ☐Transgender female(male to female)

☐ Neither exclusively male nor female ☐ Other: _____ ☐ Prefer not to disclose

RACE: _____ ☐ DECLINED PRIMARY LANGUAGE: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOW/WIDOWER ☐ DOMESTIC PARTNER

MAILING ADDRESS _____
CITY STATE ZIP

RESIDENCE ADDRESS _____
(IF DIFFERENT FROM MAILING ADDRESS)

HOME PHONE _____ WORK PHONE_____CELL PHONE _____

PREFERRED METHOD OF APPOINTMENT REMINDER CALLS (circle): CALL or TEXT and HOME#, WORK#, CELL#

EMAIL ADDRESS: _____

OCCUPATION _____ EMPLOYER _____

*DO YOU HAVE A LEGAL GUARDIAN? ☐ No ☐ If yes, NAME: _____

INSURANCE INFORMATION

*(If primary insured/card holder **is not the patient**, **please** complete INSURANCE INFORMATION section)*

Primary Insurance

PRIMARY CARDHOLDER'S NAME: _____DOB: _____

ADDRESS:_____
CITY STATE ZIP

HOME PHONE: _____ WORK PHONE _____ CELL PHONE _____

S.S.N.:_____ EMPLOYER'S NAME: _____

CARDHOLDER'S RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ OTHER:_____

Secondary Insurance

SECONDARY CARDHOLDER'S NAME: _____DOB: _____

ADDRESS:_____
CITY STATE ZIP

HOME PHONE: _____ WORK PHONE _____ CELL PHONE _____

S.S.N.:_____ EMPLOYER'S NAME: _____

CARDHOLDER'S RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ OTHER: _____

RESPONSIBLE PARTY FOR BILLING:

☐ SELF ☐ OTHER (If "Other," please complete *RESPONSIBLE PARTY PAYMENT FORM*)

OUTSIDE CONTACT INFORMATION

PRIMARY CARE PHYSICIAN NAME: _____ ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT: NAME: _____

PHONE: _____ RELATIONSHIP_____

REFERRING DOCTOR (if applicable):_____ ADDRESS: _____

PREFERRED PHARMACY (Name and Location): _____ Phone: _____

INSTRUCTIONS: Read the following carefully and initial each section that applies to you before signing below.

SELF-PAY

I have no insurance coverage or I am waiving the use of PRIVATE insurance. Therefore, I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service.

(ONLY INITIAL HERE IF YOU DO NOT HAVE INSURANCE)>>>>>>>

Initial _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the Pisgah Institute to release any information necessary to process insurance claims and request payments of benefits to be made to the Pisgah Institute for services rendered to myself or my dependents. I understand that I am responsible at the time of service for paying any required co-payment and deductible.

Initial _____

FINANCIAL AGREEMENT

I have read, understood, and signed the Patient Financial Agreement.

Initial _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I understand that I also have the right to refuse treatment by not initialing here and that refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option at our facility. G S 122C-57 I further understand that I have a right to treatment, including access to medical care and habilitation, regardless of age or degree of Mental Health/Intellectual Developmental Disability/Substance Abuse disability under G S 122C-51.

Initial _____

AUTHORIZATION FOR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the release of my protected health information to other clinicians involved in my treatment, except as I may indicate in the "Notice of Release of Initial Assessment to Referring Clinician" or in the "Request for Limitations and Restrictions of Sharing Protected Health Information (PHI)." The Pisgah Institute, P. A. has the right to refuse a request to limit disclosure of protected health information for this purpose, with limited exception.

Initial _____

MEDICAL RECORDS

While patients are entitled to access their medical records, I understand that requests are contingent upon the discretion of the patient's clinician(s) for approval of the medical record request and therefore, may take up to 30 days to process.

Initial _____

PRESCRIPTION MEDICATION HISTORY
I authorize the Pisgah Institute to request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Initial _____

CRISIS COVERAGE
I understand that the Pisgah Institute has 24-hour coverage for behavioral health crises, and that I will always be able to reach someone at the main phone number.

Initial _____

PHOTOGRAPHS
I agree to have my photograph taken for identification purposes only, and I understand that it will not be used for any other purpose.

Initial _____

PROCESSING OF PRESCRIPTIONS

- **There is a 72-HOUR PROCESSING TIME for prescription requests, including refill requests. Requests for refills that are received after 12p.m. on Friday will not be called in until Monday. Patients should allow for this processing time.**

- **There is a $15 or $30 charge per prescription, including a refill, that is written, called in, or faxed outside of a scheduled appointment. To avoid this charge, please request refills during your scheduled appointment.**

Initial_____

*******I HAVE READ AND INITIALED EACH OF THE ABOVE AGREEMENTS, AND I UNDERSTAND MY RESPONSIBILITY AS A PATIENT/ LEGAL GUARDIAN. *******

_____ Date _____
SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

Bill Barley, Ph.D.	Danielle Mitchener, P.M.H.N.P.	John C. Donkervoet, Ph.D.
Stephen E. Buie, M.D.	Nancy McKeel, Ph.D.	Adena Altschul. Ph.D.
Jeff Carter, M.D.	Doug McKee, Psy.D.	Dorcas “Cassie” Miller, Ph.D.
Mary Berg, M.D.	Elizabeth Rollins, M.D.	Keith Cox, Ph.D.
Susan Hill, Ed.D.	Rita Christensen, Ph.D.	Nicholas K. Ladd, D.O.
Sarah Wells, M.D.	Adam Hutchins, P.M.H.N.P.	L. Parks Harper, P.A.

Patient Financial Agreement

The management of mental health-benefits has become very complex and time consuming. We try to be accurate when informing you of your benefits, but as insurance companies clearly state, "**benefit information is not a guarantee of payment."** Therefore, we cannot be certain of your account balance until after we receive payment from your insurance company.

- You are responsible for knowing whether your insurance covers the services of the provider you are seeing. To contact your insurance company about this, use the customer-service numbers on your insurance card, or ask your employer.

- Co-payments are due at the time of service. This is the **total** of what the insurance does not pay. If co-payments are not made, we may be unable to continue to provide service.

- **If your balance is over 30 days past due you should speak to the patient account coordinator.**

- Insurance policies are contracts between you and your insurance company. We file claims as a courtesy, but you are responsible for issues beyond our control. If your insurance does not pay within a reasonable time, you will be responsible for the full payment.

- We will file your secondary insurance as a courtesy. However, you will be responsible for what your primary insurance does not cover and/or what your secondary insurance does not pay in a timely way.

- If your provider is not covered by your insurance company, full payment is due when services are provided.

- Charges for phone consultations are not covered by insurance. Phone consultations are defined as phone calls made to/from the patient's doctor or the doctor-on-call outside of a scheduled appointment and/or office hours.

- Prescriptions and refills are charged $15-30 per prescription written, called in, or faxed, outside of a scheduled appointment.

- There are charges for missed appointments and late cancellations, which are any appointments cancelled less than 24 hours prior to the appointment start time.

- We will only retroactively file Medicaid charges three months from the date you give us your Medicaid card.

- Patients are responsible for their appointments. Reminder calls are a courtesy. Cancellations within 24 hours and no-shows may be charged for, and you will be responsible for the charge.

I have read and understand this agreement.

_____ _____

SIGNATURE DATE

The Pisgah Institute
158 Zillicoa St.
Asheville, NC 28801

PLEASE READ BOTH NOTICES BELOW.

Notice of Privacy Practices
Written Acknowledgement Form
(Copy upon request)

I, _____, have been offered

a copy of The Pisgah's Institute's Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Guardian Date

Notice of Release of Initial Assessment to Referring Clinician

I understand that if I have been referred to The Pisgah Institute by another health care provider, my initial evaluation will be sent to that referring provider upon completion.

I have the right to prevent this disclosure of my Protected Health Information.

***Please indicate your preference by **choosing ONE** of the options below:

I understand that this information will be disclosed to the referring provider. _____ Signature of Patient or Legal Guardian Date	I DO NOT authorize this disclosure of information. _____ Signature of Patient or Legal Guardian Date

Updated: 7/2/19

The Pisgah Institute for Psychotherapy & Education, P.A.

Mental Health Authorization for Disclosure of Protected Health Information (PHI)

This applies to: APPOINTMENTS ONLY

Patient Name:_____

Date of Birth: _____/_____/ _____

I authorize The Pisgah Institute, P.A. and its employees to inform the following person(s) of my appointment time(s).

_____ _____

Person's name Relationship to patient

☐ I also authorize the person named above to make changes to my appointments.

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20_____

_____

Signature of Patient, Parent (for minor or child), Legal Guardian, or Authorized Representative Date

This applies to: PRESCRIPTIONS ONLY

Patient Name:_____

Date of Birth: _____/_____/ _____

I authorize The Pisgah Institute, P.A. and its employees to discuss prescription matters with the following person.

_____ _____

Person's name Relationship to patient

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20_____

_____

Signature of Patient, Parent (for minor or child), Legal Guardian or Authorized Representative Date