Cornerstone Psychiatry

Christy Kazmeroff PMNHP-BC, FNP-BC, ACNP-BC
www.CornerstonePsychiatry.com

PATIENT IDENTIFICATION:

Name: ____

Birthdate: _______________________ Age: ___________

Occupation: ____________________________ Marital Status: ___________________

Cell Phone Number: ____
(You will receive text message appointment reminders)

Email address: ____

Full Address: ____

Please list two Emergency Contacts:

Name: ____Phone (______)______________
Name:____ Phone:(______)______________

PURPOSE OF CONSULTATION: (Please describe your reasons for seeking treatment at this time):

____
____
____
____
____

PAST PSYCHIATRIC HISTORY:

Are you currently seeing a therapist or in the past? If yes, please include the name of your therapist and when you started treatment:

____
____

Which psychiatric medications have you taken in the past and what were the benefits and/or side effects that you experienced?

____
____
____

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GENERAL MEDICAL HISTORY:

Do you have a Primary Care Physician (PCP)? Please list name of PCP and his or her phone # and address:

____

Are you allergic to any medications? If yes, please list medications and allergic reactions:

____
____

Have you undergone any surgical procedures? If yes, please list all surgical procedures:

____
____

Have you been diagnosed with any medical conditions? If yes, please list:

____
____

Please list all current medications, supplements, herbals and OTC medication you currently take:

____
____
____
____
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Patient Name: ____

Date of Birth: ____

CONSENT TO PSYCHIATRIC SERVICES

Your signature below indicates that you have read the Office Policy and Patient Rights, which contains information on psychiatric services, sessions, professional fees, cancellation and no-show policies, billing and payments, insurance reimbursement, contacting providers, professional records, confidentiality, and you agree to abide by its terms during our professional relationship.

- I have been provided a copy of Cornerstone Psychiatry Office Policy, HIPPA and Notice of Privacy Practices, including cancellation policies, fees and confidentiality.
- I have been able to read and review the information, and I have been given the opportunity to ask questions. I understand that I may ask questions about them at any time in the future.
- I consent to accept these policies as a condition of receiving mental health services by Christy Kazmeroff PMHNP, FNP, ACNP with Cornerstone Psychiatry.

Signature: ____

Printed Name: ____

Date: ___________________

CREDIT CARD AUTHORIZATION FORM

I, the undersigned individual, authorize Christy Kazmeroff NP, Cornerstone Psychiatry, to charge my credit card for the following:

- Services received for initial evaluation or follow up appointment.
- In the event that I fail to show for a scheduled appointment
- Or do not notify the office at least 24 hours in advance if I cannot make an appointment, as agreed upon in the Office Policies Form.

Furthermore, for outstanding payments on services rendered, I authorize Christy Kazmeroff NP, Cornerstone Psychiatry, to charge my credit card for the full amount due.

I agree to not dispute charges for any of the above reasons. I further authorize Christy Kazmeroff NP, Cornerstone Psychiatry, to disclose this form and information about my attendance and/or cancellation to my credit card company if I dispute a charge. This form will be securely stored in a clinical file and may be updated by me upon request at any time.

Card Type (please circle one): Visa MasterCard Discover Amex

Card #: ____

Expiration_____________Verification/Security Code (3-digit code on the back of card):_______

Name (as printed on card):____

Billing Zip Code: ____

Signature:____

Date: ______________________________________

OFFICE POLICYS, HIPPA & NOTICE OF PRIVACY PRACTICES

This document contains important information about my professional services and business policies. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

APPOINTMENTS & FEES

Initial Psychiatric Evaluation: This will be a 60 minute appointment, and will be a full review of your medical history, psychiatric history, psychosocial and family history, as well as current or past substance use, including tobacco and caffeine. Please have the New Patient Evaluation Form completed for this first appointment, as that will allow us more time to cover the necessary information. *Fee $225*

Medication Management and Follow-up: This is typically a 25 to 30-minute appointment to fully evaluate the full effect of your medication on your health and mental wellness. During this time, every effort is made to be sure that you will have medications to carry you until your next appointment so you will not need to call the office for refills. Any laboratory or genetic testing results that have been ordered will be reviewed during this time as well. *Fee $130*

Medication Management and Follow-up 45-minute: If longer time is required for your overall care, a 45-minute follow up may be scheduled. *Fee $180*

Payment is due at the time of service. I accept cash, check, MasterCard, Visa, Discover. Any checks returned to my office are subject to an additional fee of up to $45.00 returned fee.

Cancellation Policy - The time scheduled for your appointment is assigned to you and you alone. I require a full 24 hours' notice for all cancellations except in cases of emergencies. If 24 hours' notice is not received, your credit card will be charged for the full session fee.

Medicare – Christy Kazmeroff has chosen to "Opt Out" of Medicare. This means that for all individuals currently on Medicare or eligible for Medicare, would have to file a "Private Contract" that is federally mandated in order to receive services. For any service provided, it must be paid in full at the time of service, and neither the individual nor provider may file a claim to Medicare for any reimbursement.

Medicaid – Christy Kazmeroff is not accepting any Medicaid patients. This office will not file

any claim to Medicaid for any reimbursement of your medical services at any time. Please contact your Medicaid office for further questions.

"No Show" Policy – Not coming to a scheduled appointment without any notice is known as a "No Show". If you fail to show for a scheduled appointment or do not notify the office at least 24 hours in advance that you cannot make an appointment, your credit card will be charged. However, after the second "no-show" appointment, your credit card will be charged, and you will be discharged from the practice. You will receive a letter of discharge from the practice.

Please note as well that after the third appointment that is not cancelled within the 24 hour time frame, you will be discharged from the practice.

Understanding that emergencies do happen, it is important that you stay in contact with the office. The reason for these policies is simply due to the fact that without proper follow-up we cannot continue to provide appropriate care.

In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. If you are more than 15 minutes late, your appointment will need to be rescheduled.

I make every attempt to stay on schedule to honor your time as well. Emergency appointments and crisis situations happen. Please know that I those situations very seriously, which means I may run over in time. I will make every effort to communicate this to you as well.

PROFESSIONAL FEES

The standard fee for the initial intake is $225.00, follow up appointments are $130.00 - $180.0, see above for description.

Any checks returned to my office are subject to an additional fee of up to $45.00 to cover the bank fee that are incurred. If you refuse to pay your debt, I reserve the right to use an attorney or collection agency to secure payment.

Legal fees are not reimbursed by medical insurance companies and are due and payable prior to the appointed time with a 48 hour cancelation policy. In office legal fees: $130 for 30 minuet or $260.00/hr. Out of office legal fees $325.00/hour. If not canceled prior to 48 hours the fees will remain the full fee.

Copies of Records: Records will be released and forwarded to a new psychiatric provider at no charge after a release is signed. For all other purposes, including purposes for disability filing, a fee of $3.00 per page will be due prior to the records being released.

Preparation of Letters, Medical Excuses, or Other Special Reports or Forms Completion: Please complete the patient portion of the form prior to submitting it to Cornerstone Psychiatry to be signed. If the form must be completed outside of regular appointments, a fee of $25.00 per 20 minutes will be charged and due upon completion and prior to be given to you.

INSURANCE

In effort to provide you the most personalized care, and to ensure full confidentiality of your medical records, Christy Kazmeroff NP and Cornerstone Psychiatry does not contract with any insurance companies. In order to provide you the best care and to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment.

If you have a health insurance policy, it will usually provide some coverage for mental health treatment. **I am considered an "out of network" provider.** Should you wish to request reimbursement from your insurance company, I will supply you with a receipt of payment for services for your submission. Please note that not all insurance companies reimburse for out-of-network providers, and it is your responsibility to verify this with your insurance company.

If you chose to submit to your insurance for this reimbursement, you should also be aware that they may request further information, and at that time, you will be notified of the request and asked to sign a release of information.

CONFIDENTIALITY

My policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices, attached to this document.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement with medication management can also be essential. It is my policy not to provide treatment to a child under age 15 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children ages 16 through 18, I request an understanding between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary concerning medication management. All other communication will require the child's agreement, unless I feel there is a safety concern, in which case I will make every

effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

CONTACTING ME

I am often not immediately available by telephone. For non-urgent matters, you will be able to contact me via email or phone. This information will be given to you at time of initial assessment. If for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe:

1) Contact National Suicide Hotline at 1-800-273-8255, the Colorado Crisis and Support Line at 1-844-493-8255 or Arapahoe Douglas County Mental Health Network Crisis Line at 303-730-3303.

2) Go to your Local Hospital Emergency Room.

3) Or call 911 and ask to speak to the mental health worker on call.

OTHER RIGHTS

If you are unhappy with any aspect of my practice, I hope you will talk with me so that I can respond to your concerns. Such comments will be taken seriously and handled with care and respect. You may also request that I refer you to another provider and are free to change providers at any time.

You have the right to considerate, safe and respectful care, without discrimination as to race, ethnicity, color, gender, sexual orientation, age, religion, national origin, or source of payment. You have the right to ask questions about any aspects of therapy and about my specific training and experience. You have the right to expect that I will not have social or sexual relationships with clients or with former clients.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE INVOLVES YOUR PRIVACY RIGHTS AND DESCRIBES HOW INFORMATION ABOUT YOU MAY BE DISCLOSED, AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Confidentiality

I will disclose no information about you without your written consent. My formal Mental Health Record describes the services provided to you and contains the dates of our sessions, your diagnosis, functional status, symptoms, prognosis and progress, and any psychological testing reports. You may revoke your permission, in writing, at any time, by contacting me.

II. “Limits of Confidentiality”

Possible Uses and Disclosures of Mental Health Records without Consent or Authorization

There are some important exceptions to this rule of confidentiality. If you wish to receive mental health services from me, you must sign the attached form indicating that you understand and accept my policies about confidentiality and its limits.

I may use or disclose records or other information about you without your consent or authorization in the following circumstances, either by policy, or because legally required:

· Emergency: If you are involved in in a life-threatening emergency and I cannot ask your permission, I will share information if I believe it will be helpful to your care.

· Child Abuse Reporting: If I have reason to suspect that a child is abused or neglected, I am required by Colorado law to report the matter immediately to the Colorado Department of Social Services.

· Adult Abuse Reporting: If I have reason to suspect that an elderly or incapacitated adult is abused, neglected or exploited, I am required by Colorado law to immediately make a report to the Colorado Department of Welfare or Social Services.

· Court Proceedings: If you are involved in a court preceding and a request is made for information about your diagnosis and treatment and the records thereof, such information is privileged under state law, and I will not release information unless you provide written authorization or a judge issues a court order. If I receive a subpoena for records or testimony, I will notify you so you.

· Serious Threat to Health or Safety: If you communicate to me a specific and immediate threat to cause serious bodily injury or death, to an identified or to an identifiable person, and I believe you have the intent and ability to carry out that threat immediately or imminently, I am legally required to take steps to protect third parties. These precautions may include 1) warning the potential victim(s), or the parent or guardian of the potential victim(s), if under 18, 2) notifying a law enforcement officer, or 3) seeking your hospitalization. By my own policy, I may also use and disclose medical information about you when necessary to prevent an immediate, serious threat to your own health and safety.

· Workers Compensation: If you file a worker's compensation claim, I am required by law, upon request, to submit your relevant mental health information to you, your employer, the insurer, or a certified rehabilitation provider.

Other uses and disclosures of information not covered by this notice or by the laws that apply to me will be made only with your written permission.

III. Patient's Rights and Provider's Duties:

· Right to Request Restrictions-You have the right to request restrictions on certain uses and disclosures of protected health information about you. To request restrictions, you must make your request in writing, and tell me: 1) what information you want to limit; 2) whether you want to limit my use, disclosure or both; and 3) to whom you want the limits to apply.

· Right to Inspect and Copy – In most cases, you have the right to inspect and copy your medical and billing records. To do this, you must submit your request in writing.

· Right to Amend – If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend the information. To request an amendment, your request must be made in writing, and must provide a reason that supports your request.

· Right to a copy of this notice – You have the right to a copy of this notice. You may ask me to give you a copy of this notice at any time. I reserve the right to change my policies and/or to change this notice, and to make the changed notice effective for medical information I already have about you as well as any information I receive in the future.

Complaints: If you believe your privacy rights have been violated, you may file a complaint. To do this, you may submit your request in writing to my office. You may also send a written complaint to the U.S. Department of Health and Human Services.