Wise Psychiatry

6053 S. Quebec Street ~ Suite 203
Centennial, CO 80111

PATIENT DEMOGRAPHICS
INSURANCE / AOB

Phone: 720.708.4287
Fax: 720.815.2581

First _____ Last _____ M.I. ____ Preferred Name _____
Street Address _____ Apt. _____
City _____ State ____ Zip _____ Email _____

DOB _____ Gender _____ SSN _____ Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

May we send a confidential voice message or send an appointment reminder text using any of the numbers below?

Home Phone _____ Cell Phone _____ Work Phone _____
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

RESPONSIBLE PARTY** Name _____ Relationship _____ DOB _____
Street Address _____ City _____ State ____ Zip _____
Email _____ SSN _____

May we leave a confidential voice message at any of the numbers below?

Home Phone _____ Cell Phone _____ Work Phone _____
☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No

PREFERRED PHARMACY Name _____ Phone Number _____
Address _____

INSURANCE INFORMATION - Patient has: ☐ Private Insurance ☐ Medicare ☐ Medicaid ☐ Tricare ☐ None / SELF PAY

Primary Insurance _____ Address _____
Provider Services phone number _____ Policy Effective Date _____
Policy Holder's name _____ DOB _____ Relationship _____
Policy# _____ Group # _____ BIN _____ PCN _____

Secondary Insurance _____ Address _____
Provider Services phone number _____ Policy Effective Date _____
Policy Holder's name _____ DOB _____ Relationship _____
Policy# _____ Group # _____ BIN _____ PCN _____

REQUIRED: PLEASE PROVIDE IMAGES OF THE FRONT AND BACK OF YOUR INSURANCE CARD, VIA EMAIL TO OFFICE@WISEPSYCH.COM OR VIA ONPATIENT PORTAL MESSAGE.

ASSIGNMENT OF BENEFITS - Our office will accept an assignment of benefits from your insurance company. The contract regarding your benefits is between you, your employer, and your insurance company. We are not responsible for the outcome of any claims submitted. We do not guarantee that insurance will pay for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount. Patients must sign this form and any other documents required by insurance. This instructs your insurance company to make payment directly to our office. Patients must pay the co-payment (the amount assigned as patient responsibility by your insurance) at the time the service is provided. Our office will not enter a dispute with your insurance company over a claim, beyond providing requested documentation to support the claim. We will follow the regulations of your insurance company. It is the patient's responsibility to resolve disputes over payments made or not made by your insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY MEDICAL AND MENTAL HEALTH BENEFITS DIRECTLY TO WISE PSYCHIATRY. I accept financial responsibility for charges incurred by the above-named patient.

RESPONSIBLE PARTY SIGNATURE:** _____ **DATE:** _____

** The Responsible Party is the person responsible for paying the bills. The Responsible Party must sign this form.

Printed Name: _____

SIGN THIS FORM using the pencil tool, under the "Comment" tab, or "Tools" - "Comment/Mark Up".

NOTE - Electronic signatures are legally binding. *Inserting a name above indicates that person's agreement to the terms stated.*

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EMAIL CONSENT
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EMAIL CORRESPONDENCE
DISCLOSURE OF PRIVATE HEALTH INFORMATION

Our office offers optional e-mail and patient portal correspondence to address questions and concerns regarding your care. **Email communication or portal messaging will not substitute for follow-up visits with the clinician.** In reply to your e-mail, you may be instructed to follow up via an office/video visit.

The contents of the clinician's e-mails may reference personal health information, which may include (but may not be limited to) your psychiatric diagnosis, prescribed medications, alcohol and drug history, and other medical diagnoses. Our office will NOT be held responsible for any individual who gains access to the contents of e-mails regardless of how it occurred.

HIPAA (the Health Insurance Portability and Accountability Act) was passed by the U.S. government in 1996 to establish privacy and security protections for health information. Under the HIPAA Privacy Rule patients may request that a healthcare provider communicate with him/her by alternative means. **When we send you an email, or you send us an email, the information that is sent may not be encrypted.** This means that a third party may be able to access the information since it is transmitted over the Internet. Also, once you receive it, someone may access your email account and read it. When an individual initiates email communication with a healthcare provider, the provider can assume that email communications are acceptable. On the other hand, when the provider initiates email communication with an individual, the provider must get consent from the individual.

We highly recommend communication solely through our online portal, OnPatient, which is completely secure. Information conveyed through the OnPatient portal is also preserved as part of your patient record.

However, scheduling, billing and other communications may occur outside of OnPatient, through secure emails. Reminders of upcoming appointments are sent automatically via e-mail and text, and this cannot be changed.

PLEASE CHOOSE ONLY ONE OPTION BELOW.

☐ **YES** I, (print name) _____ have read and understood the information above. **Secure email is an acceptable option for providers and office staff to communicate with me about my care.** I will be responsible for securing private emails, once they reach my email box, and are displayed on my own computer.
Patient name (if different from signer) _____

Please use the following email address: _____

☐ **NO** I, (print name) _____ have read and understood the information above. **I do not wish to receive emails pertaining to my care** and prefer to communicate entirely through the OnPatient portal. Reminders of upcoming appointments are sent automatically via e-mail and text, and this cannot be changed.
Patient name (if different from signer) _____

PLEASE SIGN.

_____ _____
Signature Date

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CUSTODIAL/CONSENT

CUSTODIAL INFORMATION (only if applicable)

In circumstances involving separation or divorce, we request that one individual be responsible for all appointments and billing. Please provide us with a copy of any legal documents establishing custodial arrangements and update them whenever necessary. If family members are unwilling or unable to follow this agreement, ongoing care may be transferred elsewhere.

Briefly Describe Custodial Arrangements (Parenting Time, Medical Decision-Making Power, Payment):

Primary Contact Responsible for appointment scheduling and billing

Preferred Contact Information

Parent Names

Parent Signatures _____ _____

Date

NOTE - Electronic signatures are legally binding. *Inserting a name above indicates that person's agreement to the terms stated.*

CONSENT TO SHARE INFORMATION WITH FAMILY MEMBERS

(Must be signed by patients over the age of 18 who CHOOSE to include parents or others in their care)

Patient Name SS# Birth Date:

I understand that the information contained in medical records is confidential. However, if I would like to have any family members/friends involved in my care, I must specifically provide consent. **I consent for Wise Psychiatry to share information about my care with the following individuals:**

Name: Phone:

Name: Phone:

Name: Phone:

By written request, this consent may be revoked at any time. The consent will automatically expire no later than one (1) year from the date signed, unless otherwise stated.

It is further understood that the information released should not be provided in whole or in part to any agency, organization, or person other than stated above. I understand that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily consent to this release of information.

For Substance Abuse Treatment Only: TO THE PARTY RECEIVING THE INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR, part 2) prohibit you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORDS APPLICABLE UNDER LAW 42 CFR PART 2.

Signature of Patient: _____ Date:

Printed Name of Signer: _____

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FINANCIAL POLICIES

We will bill your insurance and send you a statement for any balance due. These statements will be sent to your OnPatient portal for privacy, security, and ease of use. Please note that any balance due from you per your insurance carrier should be paid immediately. If you are unable to pay your balance in full, please contact us to arrange a payment plan that fits your needs. ***Balances of less than $100 may not be eligible for a payment plan.***

PAYMENT PLAN OPTIONS - Please note that any payment plan that is not adhered to or defaults will be sent to Collections for balance resolution. **ALL Payment Plans require that a credit/debit card be kept on file.** Payments will be run automatically until the balance is resolved.

Option 1: Initial Payment - 25% of your total outstanding balance, 3 Recurring Payments - weekly or bi-weekly

Option 2: Initial Payment - 50% of your total outstanding balance, 2 Recurring Payments - weekly or bi-weekly

Option 3: Initial Payment - 75% of your total outstanding balance, 1 Recurring Payment of remaining balance

Option 4: A one-time payment of the balance in full, no credit/debit card on file necessary.

COLLECTIONS - Any balance still open after ninety (90) days without a payment plan in place may be sent to Collections. You may be placed on appointment/medication restriction until the balance is resolved. You will be responsible for the **38% COLLECTIONS FEE** per date of service sent to Collections, even if you pay the balance directly to the practice. **Wise Psychiatry partners with: United Resource System.**

SELF-PAY PAYMENT POLICY - All self-pay patients are required to have a credit/debit card on file which will be charged for self-pay services prior to each appointment.
*Prices may vary if additional services are rendered.

PROVIDER	20 MIN	30 MIN	40 MIN	60 MIN/ INTAKE
Dr. Brian Wise	$195.00		$235.00	$295.00/$595.00
Kate Ziesenheim, PA		$145.00		$235.00/$430.00
Laine Morgan, NP		$130.00		$210.00/$360.00
Lizzie Parker, PA		$135.00		$225.00/$420.00

NO SHOW / LATE CANCELLATION FEES - To avoid these fees, please call at least 24 hours before the appointment to cancel or reschedule. No Show Fees **CANNOT be billed to insurance** and are the financial responsibility of the patient. No Show Fees must be paid prior to rescheduling any appointment.

No Show Fees for New Patient Appointments (1 hour) - 50% of the appointment cost

Provider	New Patient Appt Charges	No Show Charge
Dr. Brian Wise	$595.00	Current Insurance Reimbursement Rate
Kate Ziesenheim	$430.00	Current Insurance Reimbursement Rate
Laine Morgan	$360.00	Current Insurance Reimbursement Rate
Lizzie Parker	$420.00	Current Insurance Reimbursement Rate

No Show Fees for follow-up appointments will be the full reimbursement amount from your insurance provider. No Show Fees for Self-Pay appointments will be half the cost of the Self-Pay appointment.

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*By signing below, I acknowledge that I am the responsible party** for this patient account, and I have read, understand, and agree to the Wise Psychiatry Financial Policies and charges outlined above.*

Patient Name (printed) _____

Responsible Party's** Name (printed) _____

Responsible Party's** Signature _____ Date _____

** The Responsible Party is the person responsible for paying the bills. The Responsible Party must sign this form.

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Privacy Official - Catherine Wise, Office Manager
Phone - 720-708-4287
Email - office@wisepsych.com

***This notice describes how medical information about you may be used and disclosed and how you can get access to this information*. Please review it carefully.**

YOUR RIGHTS - When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record.

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. *NOTE - as a mental health practice, Wise Psychiatry does not provide psychotherapy notes to our patients - only to another agency, or a new provider.*
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record.

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications.

- You can ask us to contact you in a specific way (i.e. home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share.

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information.

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time, even if you have received the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you.

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. Legal documentation of this must be provided to the practice, to ensure the person has this authority and can act for you, before we take any action.

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File a complaint if you feel your rights are violated.

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

YOUR CHOICES - For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care (indicated on a Release of Information form, signed by you)
- Share information in a disaster relief situation.
- If you are not able to tell us your preference, (i.e. if you are unconscious), we may share your information if it is in your best interest, or when needed to lessen a serious and imminent threat to health or safety.
- We never share your psychotherapy notes unless you give us written permission. (Psychotherapy notes are never shared directly to the patient or family members - only to another health care professional or an agency)

OUR USES AND DISCLOSURES - We typically use/share your health information in the following ways:

Treat you - We can use your health information and share it with other professionals who are treating you, with written permission from you (on a Release of Information form signed by you). We will do this without written permission ONLY if you appear to be in danger, or to be dangerous to others.

Run our organization - We can use/share your health information to run our practice, improve your care, and contact you when necessary.

Bill for services - We can use/share your health information to bill and get payment from health plans or other entities.

We are allowed or required to share your information in ways that contribute to the public good, such as public health and research - We have to meet many conditions in the law before we can share your information for these purposes. Visit: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues -

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety.

Do research - We can use or share your information for health research.

Comply with the law - We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

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Work with a medical examiner or funeral director - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests -

- For workers' compensation or disability claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions - We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice - We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

By signing below, I indicate that I have read and understood the HIPAA PRIVACY PRACTICES provided to me by Wise Psychiatry.

PATIENT NAME (printed) _____

SIGN THIS FORM using the pencil tool, under the "Comment" tab, or "Tools" - "Comment/Mark Up".

Signature of Patient _____ Date: _____

GUARDIAN NAME (printed) _____

Signature of Guardian _____ Date: _____

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