PATIENT INFORMATION

Date: ____________________ Provider ____________________

Full Patient Name ______________________________ DOB ____________ Social Security # ______________

Address __________________________________ City ________________ State ______ Zip __________

Home Phone (   )________________ Work Phone (   )_________________ Cell (   )____________

Circle Appropriate Description: Male / Female Marital Status: Single / Married / Divorced / Widowed / Separated

Race: White / African American / Hispanic / Asian / Pacific Islander / Other Ethnicity: Non-Hispanic / Hispanic

Referred By ______________________________ Phone (   )______________

PATIENT EMPLOYER

Employer Name __________________________ Occupation _______________ Phone(   )______________

IF THE PATIENT IS NOT THE PERSON TO BE BILLED, PLEASE COMPLETE THIS SECTION.

Dependent Person is a: Adult Child Spouse

Student Status: Full-time Part/time School ______________________________ Level/Grade __________

Responsible Party Name ________________________________ Relationship to Patient ________________

Address __________________________________ City ________________ State ______ Zip __________

Home Phone (   )________________ Work Phone (   )_________________ Other (   )____________

CAREGIVER IF OTHER THAN ABOVE: ____

Name Phone

EMERGENCY CONTACT (In case of an emergency or if unable to contact you, whom may we notify or leave a message with:)

Name ______________________________ Relationship __________________ Phone (   )___________

INSURANCE

Primary Policy

Name of Insured Policyholder _________________________ Birthdate ________ Social Security # ____________

Address if different from patient ____

Insurance Company ____________________________ Policy/ID # ______________ Effective Date __________

Secondary Policy

Name of Insured Policyholder _________________________ Birthdate ________ Social Security # ____________

Address if different from patient ____

Insurance Company ____________________________ Policy/ID # ______________ Effective Date __________

PHARMACY

Name_____________________________ Address___________________________ City__________

State________ Zip_______ Phone(   )_________________ **OFFICE USE: REVIEWD BY**______________

FOCUS MENTAL HEALTH SOLUTIONS, PLLC

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

______________________	______________________	______________________
Patient's Last Name	Patient's First Name	Patient's DOB

By signing below, I hereby acknowledge receipt of Focus Mental Health Solutions, PLLC's Notice of Privacy Practices and consent to the uses and disclosures described in the Notice of Privacy Practices.

______________________________________ ________________

Signature of Patient (Legal or Personal Representative) Date

______________________________________ ________________

Signature of Parent/Guardian/Legal or Personal Representative Date

(Please indicate your legal authority to act for this patient) ______________________

_____ Patient Refuses to Acknowledge Receipt:

______________________/Date__________

Signature of **Staff Member**

AUTHORIZED PERSONS TO ACCESS MY INFORMATION:

NAME	**ADDRESS**	**PHONE/EMAIL**
1.		
2.		
3.		
4.		
5.		

______________________________________ ________________

Signature of Patient (Legal or Personal Representative) Date

Focus Mental Health Solutions, PLLC

Consent for Release and Use of Confidential Information
and Receipt of Notice of Privacy Practices

I, ____________________, (name of patient or legal or personal representative), hereby give my consent to Focus Mental Health Solutions, PLLC, to use or disclose for the purpose of carrying out treatment, payment or healthcare operations, some basic information contained in the patient record of ________________________.
(Patient's Name)

I understand that by law and professional ethics, what is shared in psychotherapy remains confidential unless permission has been given to share it, or except as the law or my managed care company requires.

I consent to the release of basic identifying information and the amount of the unpaid balance to a collection service or an attorney for purposes of collecting a debt if this becomes necessary.

I understand and consent to the release of information about my condition and care (including access to my chart) to the managed care company for their review for purposes of payment or quality assessment. If seeing a therapist as opposed to a Psychiatrist, I understand that some insurance companies require the therapist be supervised by a Psychiatrist. I understand the supervision will involve a review of the treatment plan and confidential discussion of my progress.

I understand and consent to the release of information about my condition and care (including access to my chart) to all the providers, both doctors and therapists, of FMHS. I understand that they provide on-call coverage for each other as well as for continuity of care should I see multiple providers within FMHS.

I acknowledge receipt of Focus Mental Health Solutions, PLLC's Notice of Privacy Practices and consent to the uses and disclosures therein.

I understand that Focus Mental Health Solution reserves the right to change the privacy practices described and that a copy of any Revised Notice will be made available to me at my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent by giving written notice of my desire to do so to my provider. I also understand that I will not be able to revoke this consent in cases where the provider has relied on it to disclose my health information.

Signed: ________________________________ Date: ________________________

By signature below, I consent and understand that a courtesy letter will be sent to my primary/healthcare physician to aid in the continuity of my care.

Primary Care Physician: ________________________________ Phone: ____________ ____________

Practice Name: ________________________________

Address: ____

Signed: ______________________________ Date: _______________

Focus Mental Health Solutions, PLLC Consent for Treatment & Financial Policy

TREATMENT

You and your clinician will work together to identify treatment goals and options. The length of time in treatment will vary according to individual needs and will be discussed throughout the course of your care. You are encouraged to talk as openly as possible about the problems you are experiencing so that your clinician can better assist you in treatment planning. Your clinician will inform you about treatment options and will include potential benefits and risks associated with those options. You do have the right to refuse treatment. As mental health treatment is an inexact science, no guarantees can be made as to the success of such treatment.

PAYMENT POLICIES

We accept cash, personal checks, debit cards, MasterCard, Visa, American Express and Discover. Payment of copays and deductibles are due at the time of service.

Focus Mental Health Solutions, PLLC schedules appointments by a block of time for each patient. If you are unable to attend your scheduled appointment, we reserve the right to charge the full office fee for any late notice cancellations or missed appointments. Your insurance will generally not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

As insurance is a contract between you and your insurance carrier, you are ultimately responsible for payment of all charges. You must provide proof of insurance at the time of your initial visit and are responsible for providing this office with changes in insurance coverage. Failure to do so may result in denial of your claim. As a matter of courtesy to our patients, we will submit charges to your insurance company. Any amount that your insurance company will not be paying such as a co-pay or deductible is due from you at the time service is rendered. If your insurance company has not paid within sixty days or denies coverage, the balance will be billed to you for immediate payment. **If you do not have insurance, payment in full is required at the time of service.** If there are any problems with meeting your financial obligations, please speak with your clinician.

Some managed care companies require the patient to get **PRIOR** approval and an authorization for their visit. If you fail to get necessary prior approval for your visit, payment in full is required at the time of service.

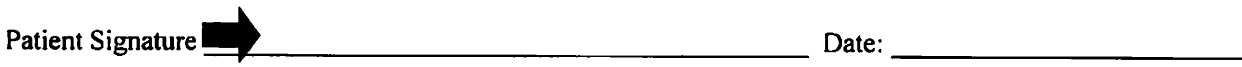
If a patient's bill remains unpaid, Focus Mental Health Solutions, PLLC reserves the right to provide your name, basic identifying information and the amount of the unpaid balance to collection services or an attorney.

ASSIGNMENT OF BENEFITS

Insurance Authorization/Release: By signature below, I hereby authorize Focus Mental Health Solutions, PLLC to release any and all information necessary concerning my diagnosis and treatment for the purpose of securing payment from my insurance company; to pursue rightful collection of monies owed by my insurance company for services rendered until the company's responsibility has been satisfied or all appeal efforts have been exhausted and thereby authorize payment of the insurance benefits directly to Focus Mental Health Solutions, PLLC for any and all services rendered.

Medicare Authorization/Release: By signature below, I request that payment of authorized Medicare benefits be made on my behalf to Focus Mental Health Solutions, PLLC for any and all services rendered to me by their providers. I hereby authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

My signature below indicates that I have read and understand the foregoing information relative to my responsibility for the services provided as well as authorizing the release of medical information as required to process claims and benefits to which I am entitled.



Patient Signature ______________________________ Date: ____________________

Patient Name Printed: ______________________________

On behalf of a minor child or guardian:
Responsible Party: ______________________________ Date: ____________________

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH AND/OR ALCOHOL AND DRUG ABUSE INFORMATION

Name of Patient: ______________________________ DOB: ______________

Address: ____

I (We) hereby authorize

Focus Mental Health Solutions, PLLC
3016 W. Charleston Blvd, Suite 150 **Ph: 702-790-2701**
Las Vegas, NV 89102 **Fax. 702-790-2706**

To ☐ **Release** ☐ **Exchange** ☐ **Receive** records or information as requested below:

Agency/Person to release/receive: ______________________________________

Address: ____

____

Specific Nature of Information to be disclosed – Please initial or place check mark by each requested item:

_____ Initial Psychiatric History/Evaluation
_____ Psychological Reports/Evaluations
_____ Lab/X-ray/Test Results
_____ Consultations
_____ Other ______________________
_____ Progress Notes
_____ Complete Medical Record
_____ Financial Information
_____ Contact/Discuss Treatment and Progress
_____ All information

For the purpose of: (Please check all that apply)

_____ Continuing (mental health/alcohol or drug abuse) treatment, care and continuity of care
_____ Therapist transition
_____ Other______________________
_____ Billing and payment related matters
_____ Legal

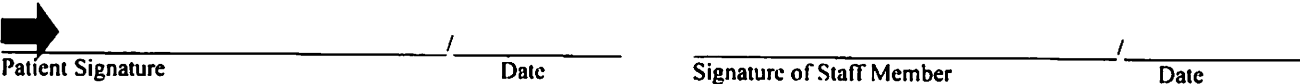
This consent is **valid for one year from date signed** (unless otherwise specified). Other Date: ________________
I understand that I may revoke this authorization by notifying Focus Mental Health Solutions, PLLC at 3016 W Charleston Blvd, Suite 150, Las Vegas, NV 89102, in writing of my desire to revoke release prior to its expiration except to the extent that action has already been taken by FMHS in reliance on the consent.

I understand that FMHS **may not condition treatment** or quality of care upon completion of this form. I understand authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization which will **prevent disclosure of information.**

I understand that FMHS may, directly or indirectly, receive remuneration from another party in connection with the use or release of disclosed health information. I understand that I also will be charged for review and copying of records.

I understand that the information disclosed may be subject to re-disclosure by the person(s) receiving it and will no longer be protected by the federal privacy regulations.

I have read and understand the terms of this authorization and release and have had an opportunity to ask questions about the use and disclosure of my health information. By signature, I knowingly and voluntarily authorize FMHS to use or disclose my health information in the manner described above.



Patient Signature / Date   Signature of Staff Member / Date

______________________ /__________   ______________________ /__________

Parent/Legal Guardian Signature   Date   Signature of Staff Member   Date

NOTICE TO PATIENT AND RECEIVING AGENCY:
Under the provisions of the Mental Health and Developmental Disabilities Confidentiality Act and applicable Federal and State Alcohol and Substance Abuse Confidentiality Acts, there may not be disclosure of any of the information provided pursuant to this release unless the patient and/or parent of the patient specifically authorizes such disclosure.

FOCUS MENTAL SOLUTIONS, PLLC

AUTHORIZATION FOR APPOINTMENT REMINDER SERVICE

Name of Patient ______________________________ DOB ________________

Address ____

I hereby authorize Focus Mental Health Solutions, PLLC, to contact the below telephone number OR email address in order to remind me of upcoming appointments.

PLEASE CHECK ONE:

☐ Telephone: ______________________

☐ Text: ________________________

☐ Email:________________________**(This will give you access to the patient portal)**

If the above number/address changes, I understand that it is my responsibility to contact Focus Mental Health Solutions, PLLC and change my information so it does not get delivered to an unauthorized party.

Focus Mental Health Solutions, PLLC schedules appointments by a block of time for each patient. **If you are unable to attend your scheduled appointment, we reserve the right to charge $50.00 fee for any late notice cancellations or missed appointments.** Your insurance will not cover this charge. If you have any questions regarding this policy, please discuss them with your clinician.

I understand that only information regarding my future appointments will be delivered, and that my information will not be given to any third party.

Patient Signature / Date

Signature of **Staff Member** / Date

Guardian Signature / Date

MEDICATION REFILL POLICY

Initial: ______• It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to seven **(7)** business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen **(14)** days before your medication is due to run out.

Initial: ______• Medication refills will only be addressed during these office hours **(Monday-Thursday 8am-4pm)**. Focus Medical Staff **will not** return any phone calls regarding refills, **refill requests will only be accepted by a medication refill request from your pharmacy**. Please notify your provider on the next business day if you find yourself out of medication after hours. No prescriptions will be refilled on Saturday, Sunday or Holidays.

Initial: ______• Refills can only be authorized on medication prescribed by providers from our office. We will not refill medications prescribed by other providers.

Initial: ______• Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible, this process **can take up to 7-10 business days**. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guaranty that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

Initial: ______• It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows, cancellations and rescheduled appointments will result in a denial of refills. **All prescriptions require a follow up appointment every 3 to 6 months.**

Initial: ______• If you have any questions regarding medications please discuss these during your appointment, this includes if you are almost out of medications you need to request a refill at the day of your visit. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.
Initial: ______• **New symptoms or events require a clinic appointment. Your provider will not diagnose or treat over the phone.**

Print Name: ____

Signature: ____ Date: __________________

Patient Rights & Responsibilities

- Patients have the right to be treated with personal dignity and respect.
- Patients have the right to care that is considerate and respects member's personal values and belief system.
- Patients have the right to personal privacy and confidentiality of information.
- Patients have the right to receive information about managed care company's services, practitioners, clinical guidelines, and patient rights and responsibilities
- Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Patients have the right to participate in an informed way in the decision-making process regarding their treatment planning.
- Patients have the right to discuss with their providers the medically necessary treatment options for their condition regardless of cost or benefit coverage.
- Patients have the right of members' families to participate in treatment planning as well as the right of members over 12 years old to participate in such planning.
- Patients have the right to individualized treatment, including
    - Adequate and humane services regardless of the source(s) of financial support,
    - Provision of services within the least restrictive environment possible,
    - An individualized treatment or program plan,
    - Periodic review of the treatment or program plan, and
    - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
- Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including
    - Resolving conflict,
    - Withholding resuscitative services,
    - Forgoing or withdrawing life-sustaining treatment, and
    - Participating in investigational studies or clinical trials.
- Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
- Patients and their families have the right to be informed of their rights in a language they understand
- Patients have the right to voice complaints or appeals about managed care company or the care provider.
- Patients have the right to make recommendations regarding managed care company rights and responsibilities policies.
- Patients have the right to be informed of rules and regulations concerning patients' conduct.
- Patients have the responsibility to give their provider and managed care company information needed in order to receive care.
- Patients have the responsibility to follow their agreed upon treatment plan and instructions for care.
- Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with the provider mutually agreed upon treatment goals.