RIVERVIEW
Community Mental Health Center

Patient Information *(Please complete these forms thoroughly, print clearly)*

Patient's Legal Name: (last)_____**(first)**_____**(middle)**_____

Preferred Name:_____**Date of Birth:**_____/_____/_____

Address:_____**City, State, ZIP:**_____

Phone:(home)_____-_____-_____**(cell)**_____-_____-_____**(work)**_____-_____-_____

E-Mail:_____ **Pharmacy:**_____

Pharmacy Phone: _____

Gender Identity: ❑ Female ❑Male ❑Transgender Male to Female
❑Transgender Female to Male ❑ Decline to say
❑ Other_____

Race: ❑Native American ❑ Asian ❑ Hawaiian/ Pacific Islander
❑ African American ❑ Caucasian
❑ Hispanic ❑ Decline to say ❑ Other_____

Patient Social Security Number: _____-_____-_____

Marital Status: ❑ Single ❑Married ❑Widowed ❑Divorced
❑Other: _____

Responsibility for Patient's Care/ Payment

Responsible party: ❑Self ❑Guarantor/ Legal Guardian ❑Other_____

Relationship to patient: _____

Responsible party name: _____ **DOB:** _____/_____/_____

Phone #_____-_____-_____

Address:_____

City, State, ZIP:_____

Insurance Information *(please provide us with copies of all insurance cards)*

- The insurance policy and/or plan was chosen by you and/or your family member**. It is your responsibility to understand the frequencies, clauses, and coverages in your insurance policy/plan**. If we are providers, our office will request a basic breakdown of benefits to determine an "**approximate"** out-of-pocket co-payment/ co-insurance for your mental health visit. Please be advised, coverages vary by plan types. It is not a guarantee of payment by your insurance carrier, and **you are responsible for all charges, whether paid by your insurance or not.** ***Initial***_____
- We are more than happy to work with your insurance company to maximize your mental health benefits. We will gladly file your mental health claims as a courtesy to you. Dr. Olivera has elected to participate with certain insurance companies and accept their contracted fees**.**
Payment is due at the time of the session unless other arrangements have been made. We will file your insurance claim, but you are responsible for deductibles, co-insurances, and co-payments. It is your responsibility to familiarize yourself with your insurance benefits and to call your insurance company to have the authorization for your session sent to this office. ***Initial***_____
- Amounts not paid within 30 days will encourage monthly financial charge of 1.5%, calculated from the date of service. In the event that collection measures become necessary, all related expenses, including agent and/or attorney's fees, will be the responsibility of the patient, parent, or legal guardian. ***Initial***_____
- **Self-Pay:** ***Payment is due at the time of the appointment unless other arrangements have been made.*** ***Initial***_____

Primary Insurance Carrier:_____ **Member ID:**_____ **Group #:**_____

Policy Subscriber Name:_____ **Policy Subscriber DOB**_____/_____/_____

Secondary Insurance Carrier: _____ **Member ID:** _____

Prescription Coverage Carrier:_____ **Member ID:**_____ **RxBIN:**_____

PCN: _____ **Rx Group #:** _____

Emergency Contact Information ***This individual will only be contacted in the event of a medical emergency, if we are unable to reach patient.***

Emergency contact name: _____ **Relation:**_____

Phone number:_____-_____-_____

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Notice of Patient Rights and Responsibilities

This document is meant to inform our patients of their rights and responsibilities while they are undergoing medical care. To the extent permitted by law, patient rights may be delegated on behalf of the patient to his or her guardian, next of kin, or legally authorized responsible person if the patient: a) has been adjudicated incompetent in accordance with the law, b) is found to be medically incapable of understanding the proposed treatment or procedure, c) is unable to communicate his or her wishes regarding treatment, or d) is a minor. If there are any questions regarding the contents of this notice, please notify any staff member. HIPPA compliance is our main goal, and a brochure is available for all patients.

Patient Rights

1. **Access to Care.** You will be provided with impartial access to treatment and services within this practice's capacity and availability and in keeping with applicable laws and regulations. This is true regardless of race, creed, sex, national origin, religion, disability or handicap, or source of payment for care or services.
2. **Respect and Dignity.** You have the right to considerate, respectful care and services at all times and under all circumstances. This includes recognition of psychosocial, spiritual, and cultural variables that may influence the perception of your illness.
3. **Privacy and Confidentiality.** You have the right, within the law, to personal and informational privacy.

   This includes the right to:

   - Be interviewed and examined in surroundings that ensure reasonable privacy
   - Expect that any discussion or consultation regarding care will be conducted discreetly
   - Expect all written communications pertaining to care to be treated as confidential
   - Expect medical records to be read only by individuals directly involved in care, quality assurance activities, or the processing of insurance claims. No other persons will have access without your written authorization.

4. **Personal Safety.** You have the right to expect reasonable safety regarding the practice's procedures and environment.
5. **Identity**. You have the right to know the identity and professional status of any person providing services and which physician or other practitioner is primarily responsible for your care.
6. **Information**. You have the right to obtain complete and current information concerning your diagnosis (to the degree known), your treatment, and any known prognosis. This information should be communicated in terms that you understand.
7. **Communication**. If you do not speak or understand the predominant language of the community, you should have access to an interpreter. This is particularly true when language barriers are a continuing problem.
8. **Consent**. You have the right to information that enables you, in collaboration with the physician, to make treatment decisions.
   - Consent discussions will include an explanation of the condition, the risks, and benefits of treatment, as well as the consequences of no treatment.
   - Except in the case of incapacity or life-threatening emergency, you will not be subjected to any procedure unless you provide voluntary, written consent.
   - You will be informed if the practice proposes to engage in research or experimental projects affecting its care or services. If it is your decision not to take part, you will continue to receive the most effective care the practice otherwise provides.
9. **Consultation**. You have the right to accept or refuse medical care to the extent permitted by law. However, if refusing treatment prevents the practice from providing appropriate care in accordance with ethical and professional standards, your relationship with this practice may be terminated upon reasonable notice. ***We do offer telepsych follow-up appointments when enough notice is given. A licensed clinician can and will facilitate your appointment with you over the phone. The charge for this time would be the same as if you had come into the office.***
10. **Charges**. Regardless of the source of payment for care provided, you have the right to request and receive itemized and detailed statements of any and all billed services provided by Riverview Community Mental Health Center.
11. **Rules and Regulations.** You will be informed of the practice's rules and regulations concerning your conduct as a patient at this facility. You are further entitled to information about the initiation, review, and resolution of patient complaints. ***You have the right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, please inform the office immediately and discuss the situation***.

I have read and understand the above information regarding my rights and responsibilities as a patient.

_____ _____

Patient/ Legal Guardian Signature ***Date***

_____

Name (please print)

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Health Insurance Portability and Accountability Act

In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA). One component of HIPAA was to streamline the process to exchange information and to make health information more readily accessible to patients. The HIPAA Privacy Rule went into effect it April 2003 and created a federal standard for protecting the privacy of health information. The Privacy Rule also requires DOH to comply with Florida laws that provide greater protection to patients.

The Privacy Rule generally prohibits the use and disclosure of health information without written permission from the patient. The Privacy Rule also gives patient's rights to access their medical and billing records, request amendments to those records, and obtain an accounting of disclosure of protected health information. The Department's Notice of Privacy Practices further describes the use and disclosure of patient medical information and how patients may obtain access to their information. If you believe your privacy rights have been violated by a DOH employee, you may file a complaint with the Department of Health's Inspector General at 4052 Bald Cypress Way, BIN A03/ Tallahassee, FL 32399-1704/ telephone 850-245-4141 or with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W./ Washington, D.C. 20201/ telephone 202-619-0257 or toll free 877-696-6775.

The session content and all relevant materials to the client's treatment will be confidential unless the client requests in writing (release of Information form) to have all or portions of such content released to specifically names person(s). Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts their self in a manner which there is substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has reasonable suspicion that a client or other name victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. If the provider has reasonable suspicions as stated above in the case of an elderly person who may be subject to abuse.
5. If records are court ordered.

HIPPA Acknowledgement

My signature confirms that I have been offered the opportunity to view the Notice of Privacy Practices of Riverview Community Mental Health Center. A copy of this document is available for my viewing, as well as available on our website.

_____ _____

Patient/ Legal Guardian Signature ***Date***

About Therapy/ Treatment

I understand my diagnosis and treatment by the clinical staff at RIVERVIEW COMMUNITY MENTAL HEALTH CENTER, LLC may be conditioned upon my consent as evidence of my signature on this document. The major goal is to help you identify and cope more effectively with problems in daily living and deal with internal conflicts to achieve more satisfying personal and interpersonal relationships. This purpose is accomplished by:

1. Increasing personal awareness of obstacles and strength.
2. Taking personal responsibility to make the changes necessary to achieve your goals.
3. Identifying specific treatment goals.
4. Utilizing all available community, medical and self-help resources.

Consent for Counseling and/or a Psychiatric Evaluation and Treatment

By signing below, you are stating that you have read and understood all policy statements and you have had your questions to answered to your satisfaction. You accept, understand, and agree to abide by the contents in terms of this agreement and further consent to participate in psychiatric treatment and/or counseling. You may withdraw from treatment at any time. You understand a copy of the office notice of privacy practices is available upon request. This document will describe how medical information can be used and disclosed.

_____ _____

Patient/ Legal Guardian Signature ***Date***

RIVERVIEW
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Record Keeping

We will keep records of our sessions. These records are kept ensuring a direction of your sessions and continuity in service as well as insurance reimbursement. They will not be shared except in respect to the limits of confidentiality discussed in the confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be longer. Records will be kept either electronically or in a paper file and stored in a cabinet in my office.

Initial _____

Discharging of Patient

We reserve the right to terminate care with a patient at the provider's discretion. Reasons for a patient discharge include but are not limited to untimely payment of service fees, patient behavior in office/ on phone, conflicts of interest, failure to comply with treatment plan, the patient needs are beyond our level of care.

Initial _____

Cancellations and Missed Therapy Sessions

Psychotherapy session that are cancelled under a 48-hours-notice, will accrue a $40 missed appointment/ late cancellation fee. You may leave messages with us 24 hours day, seven days a week through our answering service when the office is closed. This fee is not covered by your insurance.

Initial Psychotherapy appointments do require a $40 deposit, which is refunded after the initial session.

Initial _____

New Patient Estimate Explanation

The estimate below is the range of costs/cost that is likely for most new patients. Until we complete an initial evaluation, and begin care, we will not have a clear picture of your specific diagnosis, issues, and needs. We typically see therapy patients for 25 sessions for a total cost of $*3850.00*. But in some/many cases a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate. We typically see medication management patients for a total cost of $1900. But in some/many cases a patient's issues may be more complicated, so we may need additional sessions during the time covered by this estimate.

Continuing Patient Explanation

The estimate below is the range of costs/cost that we think is likely for your care over the time period covered by this estimate. However, depending on how treatment progresses, more or fewer sessions or appointments may be needed. Contact: If you have questions about this estimate, please contact our billing department at 305-279-2276.

Details of the Estimate

The following is a detailed list of expected charges for psychological services scheduled:
_____ to _____. The estimated costs are valid for 12 months from the date of this Good Faith Estimate.

Service	***Diagnosis Code*** *ICD-10 (once determined during appointment)*	***Service code***	***Quantity*** *(# of sessions/ units. Give number/ range*	***Cost per unit***	***Expected cost***
Psychiatric Diagnostic Evaluation		90792	1	$250.00	$250.00
Follow up medication management		99214	12	$150.00	$150.00
Psychotherapy Session		90837	24	$150.00	$150.00

Scheduled Provider(s):	**Total Estimated Cost:**
	NPI: 1700203601 TIN: 46-1494966
	Locations: 451 SW Bethany Drive, PSL, FL 34986
	865 SE Monterey Commons Blvd. Stuart, FL 34996

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Disclaimer

This Good Faith Estimate shows the costs of services that are reasonably expected for the expected services to address your mental health care needs. The estimate is based on the information known to [us/me] when [we/I] did the estimate.
The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

You may contact the billing department at the contact listed above to let them know the billed charges are at least $400 higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available. You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a $25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to: www.cms.gov/nosurprises or call CMS at 1-800-985-3059. For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call CMS at 1-800-985-3059.

- **This Good Faith Estimate is not a contract. It does not obligate you to accept the services listed above.**
- **Keep a copy of this Good Faith Estimate (GFE) in a safe place. If at any time during your treatment the above expected charges do not match with your payments, you have the right to dispute it at any time .**

Your signature below indicates that you have read and acknowledged this entire form and consent to its terms. A copy of this form may be provided to you upon request.

_____

Patient/ Legal Guardian Signature

_____ _____

Name (please print) ***Date***

Scan this QR Code to visit our Patient Resources Page for more info.

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Community Mental Health Center

865 SE Monterey Commons Blvd
Stuart, FL 34996
o 772-266-4713
f 772-888-9082

451 SW Bethany Drive, Suite 103
Port Saint Lucie, FL 34986
o 772-301-1354
f 772-281-2706

Authorization to Obtain and Release Information

This form allows us to obtain or release specific or all medical records of patient to a third party.

Patient Name: _____ Date of Birth_____

Phone Number: _____ Expiration of Form:_____

This will authorize Riverview Community Mental Health Center to disclose to and/ or obtain patient information from and/ or to:

Name of Person or Organization: _____ Relationship: _____

Address: _____ Phone: _____ Fax: _____

Information to be released:

___ Psychiatric Evaluation
___ Laboratory Reports (HIV, Hepatitis, TB)
___Urine Analysis
___ Medical History
___Intake Evaluation
___ Discharge Summary
___ Medication Information
___ Patient Letters (if applicable)
___ Presence in Treatment
___ Treatment Dates
___ Progress Notes
___ Return to Work
___ Scheduling Information/ Changes
___ Psychotherapy Notes
___Other information (specify): _____

The above-named person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this practice. Your revocation will be honored except to the extent that is been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be re-released. This and other specific rights regarding handling of your health information are outlined in our Privacy Practices document.
- The information you are authorizing to be released could be re-released or disclosed by the recipient, such additional disclosures or releases may not be prohibited by law. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment expect to the extent that the information being requested may assist your health care provider in determining appropriate treatment. Your refusal to sign this authorization will not affect your eligibility benefits.

I acknowledge, and consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

I acknowledge, and consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information. I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Patient/Legal Representative Signature ***Printed Name***

_____

Date