Patient Information

(please complete these forms thoroughly, print clearly

Patient's Legal Name: ______________________________ **DOB:** ______________________________

Preferred Name: ______________________________ **Phone:** ______________________________

Address: ______________________________ **Patient Social Security #:** ______________________________

Email: ______________________________ **Gender Identity:** ☐Female ☐Male ☐Transgender ☐Other: ____________

Pharmacy: ______________________________

Pharmacy Phone #: ______________________________

Race/ Ethnicity: ☐Native American ☐Asian ☐Hawaiian/ Pacific Islander ☐Hisparnic ☐African American ☐Caucasian ☐Other: ____________

Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed ☐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**__________
- **As of January 1, 2024, there will be a card processing charge of 3% to all card transactions.** Amounts not paid within 30 days will encourage a 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**__________

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: ______-________-________

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. HIPAA compliance is our main goal, and a brochure is available for all patients.

Health Insurance Portability and Accountability Act (HIPAA)

What is HIPAA? HIPAA is an acronym for the Health Insurance Portability and Accountability Act. Among other measures, the Act led to the establishment of federal standards for safeguarding patients' "Protected Health Information" (PHI) and ensuring the confidentiality, integrity, and availability of PHI created, maintained, processed, transmitted, or received electronically (ePHI).

Self-Pay New Patient Estimate Explanation

The following is the range of costs/cost that is likely for uninsured new/ established 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.

Initial Psychiatric or Psychotherapy Evaluation - $250, Psychiatric or Psychotherapy Follow-Up - $150

Patient Rights, HIPAA Acknowledgement & Self Pay Disclaimer

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 in further explanation is available for my viewing, as well as available on our website.

______________________________ ______________________________

Patient/ Legal Guardian Signature **Date**

For more information on our policies and your rights, scan this QR code:

https://riverviewcmhc.org/patient-resources/

Consent for Psychiatric and Psychotherapy 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.

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.

______________________________ ______________________________

Patient/ Legal Guardian Signature **Date**

Record Keeping

We will keep records of our sessions. These records are kept ensuring the 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 could 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

As a courtesy, all patients are called to be reminded of scheduled appointments. We ask that all patients call to cancel in the event they are unable to make a scheduled appointment. **As of January 1, 2023 we will be charging for all missed appointments that occur without proper cancelation (24-hours in advance) Medication Management Fee: $25 - Therapy Fee: $40.** You may leave messages with us 24 hours a day, 7 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 ________________

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.

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Patient/ Legal Guardian Signature

______________________________ ________________

Name (please print) **Date**

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

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
___Other information (specify):
___ Patient Letters (if applicable)
___ Presence in Treatment
___ Treatment Dates
___ Progress Notes
___ Return to Work
___ Scheduling Information/ Changes
___ Psychotherapy Notes

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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 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 protected health information as stated.

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

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Date