Virginia South Psychiatric & Family Services

Patient's Name: _____ Date of Birth: _____
Social Security #: _____ Gender at Birth: ◯ Male ◯ Female
Preferred Name / Nickname: _____ Preferred Gender: ◯ Male ◯ Female
Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widow
Race/Ethnicity: ◯ White/Caucasian ◯ African American ◯ Asian ◯ Hispanic/Latin ◯ Other ◯ Prefer not to answer
Address: _____
City: _____ State_____ Zip Code: _____
Phone: _____ Mobile: _____ E-Mail: _____
Preferred Phone: _____ Choose 1 Method of Contact for Appt. Reminder: Voice Text Email

Failure to receive an email or phone call reminder does not absolve you from keeping track of your own appointments.

Patient's Current Medications:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Preferred Pharmacy: _____ **Phone:** _____

If you are taking any other medications than what is listed above please provide the doctor with a detailed list.

General Information:

Reason for Visit: _____ Allergies: _____
Are you currently pregnant or plan to become pregnant within the next 6 months? ◯ Yes ◯ No
Do you smoke? ◯ Yes ◯ No ◯ Occasionally Is there a history of mental illness in the family? _____
Has the Patient being seen today ever met with another Psychiatrist and/or Therapist? _____
Previous Hospitalizations: ◯ Yes ◯ No If yes please provide hospital name as well as date and reason for hospitalization: _____

Insurance Information:

(1) Primary Insurance: _____ Policy ID #: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Policy Holder SSN: _____ Policy Holder Employer: _____
(2) Secondary Insurance: _____ Policy ID #: _____
Policy Holder Name: _____ Policy Holder Date of Birth: _____
Policy Holder SSN: _____ Policy Holder Employer: _____

Please complete if patient being seen is under the legal age of 18 years old:

Parent/Guardian Name: _____ Relationship to the Patient: _____
Contact Number: _____

Parent/Guardian Name: _____ Relationship to the Patient: _____
Contact Number: _____

Consent/Release for Third Party Access:

I authorize VSPFS to disclose protected healthcare information with the family/others listed below.

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Emergency Contact: _____ Relationship / Phone #: _____

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

Virginia South Psychiatric & Family Services

Consent to Treatment & Assignment of Benefits

I hereby authorize VIRGINIA SOUTH PSYCHIATRIC & FAMILY SERVICES, P.C. to furnish to the insurance company(s) or to a designated attorney, all information which attorney or insurance company requests.

I hereby assign to VIRGINIA SOUTH PSYCHIATRIC & FAMILY SERVICES, P.C. all money to which I am entitled for medical expenses relative to the services rendered by professionals of this company, but not to exceed my indebtedness. It is understood that any money received from the above-named insurance company, over & above my indebtedness, will be refunded either to me or my insurance company, when my bill is paid in full. I agree to pay my co-payment/deductible at the time of service.

I hereby agree it is my responsibility to advise VIRGINIA SOUTH PSYCHIATRIC & FAMILY SERVICES, P.C. of any insurance changes in a manner to allow time for appropriate authorizations to be received prior to my appointment.

I hereby agree that I am financially responsible for all non-covered charges. I acknowledge it is my responsibility for all charges denied due to my not notifying VIRGINIA SOUTH PSYCHIATRIC & FAMILY SERVICES, P.C. of any insurance change until after services were rendered.

I further agree, in the event of nonpayment, to bear the cost of collections and/or court cost & reasonable legal fees should this be required.

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

Statement of Patient Rights

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other information kept private and only disclosed to designated individuals given on a release form signed by the patient.
- Patients have the right to information from staff/providers in a language they can understand as well as an explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices regardless of cost coverage.
- Patients have the right to get information about services offered by their providers and patient role in the treatment process.
- Patients have the right to request professional information about their provider.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide suggestions on office policies and procedure.
- Patients have the right to complain and to know about the complaint, grievance, and appeals process.
- Patients have the right to know about State and Federal laws governing their rights and responsibilities.
- Patients have the right to participate in the formation of their plan of care.

I understand my rights as stated above:

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

Virginia South Psychiatric & Family Services

Prescription Refill and Cancelation Policy

1. Please call or have your pharmacy fax us between business hours Monday through Friday for any prescription refill requests.
2. In order to fill your prescriptions in a timely manner please submit your request seven to ten days prior to your last dose.
3. If you miss two or more consecutive appointments in a row no future medications will be refilled by your doctor until you have been seen for an appointment.
4. You may be charged a **RE-INSTATEMENT FEE** for missing, rescheduling or canceling three consecutive appointments. This fee will be required to be paid in full before you can schedule another appointment with our office.
5. We allow a 15min grace period between your appointment time and the time you check in. If you are more then 15min late you may be asked to reschedule.

Statement of Patient Responsibilities

- If you miss 3 or more consecutive appointments you will be considered a non-active patient with Virginia South and will consider these missed appointments as you terminating your services with our practice.
- Patients are responsible for providing their medical provider with information needed to deliver quality care.
- Patients are responsible for informing their provider when/if their treatment plan is no longer effective.
- Patients are responsible for following their treatment plans and to inform their provider of any changes to their treatment plan that is made by any other physicians. This includes changes to or the addition of medications.
- Patients are responsible for treating Virginia South staff and providers with dignity and respect.
- Patients should not be involved in any conscious behavior that could harm the lives of their provider, office staff or other patients.
- Patients are responsible for notifying Virginia South of any insurance changes and in a manner to allow time for appropriate authorizations to be received prior to my appointment.
- Patients are responsible for all of their copayments, deductibles, balances and non-covered charges.
- Patients are responsible to contact our office to provide us information if you are leaving our care, or being seen at another practice for psychiatric care.
- Patients are responsible to not drive or operate machines if being prescribed medications that may make you drowsy.

To reach your provider or on-call doctor after office hours or on weekends please contact 804-965-7953.

For Crisis Intervention please call your local Community Services Board

****In the case of an emergency please call 911****

I understand the refill/cancelation policies and patient responsibilities stated above:

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

Virginia South Psychiatric & Family Services

Patient Safety Information

- Take medications as prescribed by your doctor and do not alter medication dose or frequency without talking to your doctor
- Keep your medication in a secure location or if possible, in a locked medicine cabinet to prevent theft, loss, or accidental ingestion by a pet, child or other persons.
- Do not give medications to anyone else for their use.
- Read and follow all pharmacy warning and safety labels on your prescribed medications.
- If you experience any adverse reactions or side effects contact your doctor immediately.
- If you develop a rash or experience dizziness stop taking your medication and contact your doctor immediately.
- If you feel suicidal/homicidal contact your doctor or go to the nearest ER for immediate assistance.

I understand and have read all patient safety information and will do all necessary things as advised for my safety and the safety of others:

_____	_____	_____
Patient/Guardian's Signature	**Printed Name**	**Date**

Communications Consent

If at any time I provide an email address, phone or cellphone number at which I may be contacted, I consent to receiving unsecure communications from Virginia South Psychiatric and their affiliates (which include debt collectors), at the phone, email or text address I have provided or you. Healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care or regarding an account balance or bill. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update **all your demographics and consents** to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

_____	_____	_____
Patient/Guardian's Signature	**Printed Name**	**Date**

Virginia South Psychiatric & Family Services

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.

1. **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information (as necessary) when contacting you during courtesy phone appointment reminder calls.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases, Health Oversight: Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, and Organ Donation: Research, Criminal Activity, Military Activity and National Security, Worker's Compensation. Inmates: Required Uses and Disclosures.

Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

2. **Your rights**

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

3. **Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

Virginia South Psychiatric & Family Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION PRIMARY CARE PHYSICIAN

Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. Please complete the below information.

IF YOU DO NOT HAVE A PRIMARY CARE PHYSICIAN PLEASE CHECK DO NOT, THEN SIGN AND DATE THIS FORM

Patient Name: _____ ***Date of Birth***: _____

Primary Care Physician: _____

(PCP Office and Doctor's Name)

Office Phone: _____ ***Office Fax:*** _____

Please select one of the following:

◯ I give consent for information regarding my treatment to be shared with my PCP

◯ I **DO NOT** wish to have information regarding my treatment with this practice released to my PCP

_____ _____ _____

Patient/Guardian's Signature **Printed Name** **Date**

A copy of this authorization may be used in lieu of the original.

I understand I may revoke this authorization by written notice but the revocation will not apply to previously released information. This release of information expires in 60 days following completion or termination of treatment. This information may be shared by phone, in writing, or by fax.