Salveo Integrative Health

311 Gwinnett Drive, Lawrenceville, GA 30046
Phone#: 770-910-9196 Fax #: 770-910-9197

Patient Name: ____
Date of Birth: ________________________SSN: __________________________________
Address: ____
City, State, Zip: ____
Home Phone: _________________________ Mobile: ________________________
Preferred Pharmacy Name: ____________________________ Phone#________________
PARENT INFORMATION
Name: ____
Birthdate: ______________________ SSN: ______________________________________
Address: ____
City, State, Zip: ____
e-mail address: ____
****

Responsible Party

[ ] Same as above

Relationship to patient: ____
Name: ____
Address: ____
City, State, Zip: ____
Home Phone: ______________________ Work Phone: ____________________________
Mobile: _____________________ e-mail address: __________________________________
Employer: ____
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Insurance

Primary
Insured's Name: _____________________________
SSN: ________-________-__________
Relationship to Patient: ________________________
ID Number: __________________________________
DOB: ____

Secondary
Insured's Name: _____________________________
SSN: ________-________-__________
Relationship to Patient: ________________________
ID Number: __________________________________
DOB: ____

Updated 12/2016

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Treatment Consent/Authorization for Disclosure

Consent to Treatment

I, the undersigned, do voluntarily consent and authorize outpatient treatment as judged to be necessary by my clinician. Such treatment may include diagnosis/assessment procedures, psychotherapy and pharmacotherapy. I understand that this consent authorizes the use of standard and customary community standards, and I have been advised of the potential risks and benefits associated with treatment. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between patient and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or discontinue treatment, I will not hold Salveo Integrative Health or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws require that my psychiatrist/therapist report all cases in which there exists a specific potential harm to others or in cases of reported or suspected physical, sexual and/or neglect of children which are required by Georgia law.

Authorize for Disclosure of Information

The undersigned hereby authorizes Salveo Integrative Health and its staff to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel;
- Any attorney, collection agency or other persons or entities engaged in the collection of responsible party to Salveo Integrative Health
- Any other healthcare professional staff providing needed care;
- Any person, corporation, public or private agency to the extent necessary for Salveo Integrative Health to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification;
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review;
- Any Salveo Integrative Health employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records;
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to Salveo Integrative Health.

____ ________________

Patient Name **Date**

____ ________________

Signature of Parent/Guardian **Date**

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Policy and Procedure

Please initial on the lines below to acknowledge that you have read and understand our policies.

_______**INSURANCE:** Benefits quoted are just estimates. **Final copayment, co-insurance, and deductible amounts are determined by your insurance when the claim is processed.** Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor. If your insurance company does not pay the practice within a reasonable period, we may look to you for payment. If we later receive a check from your insurer, we will refund any over payment to you. You are responsible for informing us of any **insurance changes prior to your appointment**.

_______ **PAYMENT FOR SERVICES:** **Payment for services is required at the time of service.** This includes copayments, deductibles, and co-insurance amounts. We reserve the right to reschedule appointment due to inability to pay for services. We accept Cash, Personal Checks and all major Credit Cards.

______ **RETURNED CHECKS: There will be a $35 fee for any check retuned unpaid, regardless of the reason.** Salveo reserves the right to refuse to schedule appointments or cancel any scheduled appointments until payment is made in full for a return check.

______ **APPOINTMENTS:** Appointments are held especially for you and they are a valuable resource at our practice. If you are unable to keep your scheduled appointment, please provided a minimum of 24hr notice. We charge a **$50.00 for No Show Fee or $35 same day cancellation of appointments.** Fees for missed appointments are due at your next appointment. **Appointment reminder calls are attempted as a courtesy for you, but it is your responsibility to keep track of appointment dates and times.**

______**WAITING TIMES:** Our providers do their best to see you in a timely manner. If you are more than 15 minutes late for your appointment, we reserve the right to reschedule your appointment.

______ **FORMS AND LETTERS:** Thank you for understanding that our provider's priority each day must be to see the patients in the office, therefore, they will complete forms and letters as time permits. Providers will only fill out forms or write letters after patient has been seen **at least 6 times consecutively**. Most form/letters will be completed within 2-4 weeks. Charges vary depending on provider's time spent on completion. We reserve the right to charge for forms or letters completed by providers. Fees are based on the provider's time required to complete the request, and **ranges from $35 to $150**

______ **MEDICAL RECORDS REQUEST:** Medical records can be sent to another provider free of charge upon completion of a medical records release form. If you would like a copy of your medical records. An admin, search, retrieval fee **of $25.88** will be charged along with a **coping fee of $.97 for the first 20 pages, $.83 for page 21-100** and **$.66 for every page after 100 pages**.

______ **AFTER HOURS CALL/EMERGENCY:** Our voicemail system is available 24 hours a day and 7 days a week. Calls are normally returned during regular business hours which are Mon-Fri 9am-5pm.

_____ **PRESCRIPTION REFILLS: Physician patients only):** All prescriptions refills request should be handled during scheduled office appointments or by leaving a message on the prescription refill line. **Refill requests left on the prescription line will be handled within 3 business days** (excluding holidays or weekends).

_____ **PRESCRIPTION ADMINISTRATIIVE FEES:** A **$20.00** fee will be assessed for each prescription written outside of an appointment and must be paid for at the time of pick up. Please allow 48 hours to prepare your prescription.

_____ **MEDICATION CHANGES:** Will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, this can be addressed over the phone with support staff. After hours' issues will need to be directed to urgent care or emergency facilities

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______ **URINE DRUG SCREENS:** UDS are a necessary part of therapy and per DEA regulations anyone 18 years or older can and will be urine drug screened when being prescribed controlled substances. The cost associated with this testing in our clinic is **$50.00**. Most insurance companies do not cover the cost of the urine drug screen which is why it is the patient's responsibility to pay this cost up front.

_____ **TERMINATION OF CARE:** Salveo's goal is to provide services to patients until the patient and the physician/therapist feel treatment goals have been accomplished. Patient may wish to terminate their care with Salveo at any time. **Patients who have not been seen for greater that 6 months, will be considered self-terminated, and their chart will be closed.** Salveo may find it necessary to terminate the patient/provider relationship for non-payment of account balance, or due to inappropriate behavior or conduct toward administrative or clinical staff. Salveo will make all notifications of termination of care in writing.

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Authorization to communicate with third parties

You have the right to request that we restrict how protected health information about you is used or disclosed. Most patients have family members or friends that occasionally become involved in their care. (For example, your spouse calls to confirm your appointment time; OR your adult child calls with questions about your medications.) Please list any restrictions to the information we can communicate about you with those you have listed below. (Example: Appointments only, financial matters only; Medications Only, etc. If there are no restrictions, please list "NONE" beside their name).

Please list below any persons you will allow us to talk with about you. (If you prefer we do not speak with anyone, please write "NO ONE" across this section.

Name	Relationship	Phone Number	Restrictions (as defined above)

I understand that I have the right to revoke this authorization in writing at any time. I request that my confidential information be handled in the manner listed above and authorize Salveo Integrative Health staff to disclose information only to those individuals listed above and in the manner stated for oral and written communications. Any other release of information will require a signed authorization for Release of Medical Information.

____ _________________________

Signature of patient/guardian Date

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This consent and authorization shall expire 1 year date of signing unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

____ _________________________

Signature of patient/guardian Date