New Patient Registration Information

White Oak Psychiatric Associates

FINANCIAL POLICY

White Oak Psychiatric Associates wants to provide our community with behavioral health services and, at the same time, keep costs under control. To do this, we need your help. We ask you to read our payment policy listed below.

- Your bill is based on the services you received. You are responsible for paying the bill if your insurance company does not cover all the costs.
- What your health insurance covers is based on an agreement between the company, or person who employs you, and the insurance company.
- You need to contact your insurance company with any questions about what they will cover.
- We know that temporary financial problems can sometimes prevent you from making a payment on your account on time. If this happens, you need to contact us at (816) 886-2184 at once so we can help you with this problem. White Oak Psychiatric Associates will help arrange a budget plan.
- No Show fees are assessed at $50.00, Cancellations within 24 hours of appointment are assessed at $40.00.

IF YOU DO NOT HAVE HEALTH INSURANCE
Your Responsibility

- You must pay your entire bill at the time of service or inform us of your inability to pay.

Our Responsibility

- White Oak Psychiatric Associates will provide the services you need once a payment arrangement has been made.

IF YOU HAVE HEALTH INSURANCE
We participate with many insurance companies. This means we have signed a contract with them to provide care for the people they cover. The contracts are not all the same, and certain services may not be covered depending on your health benefits.

If we DO participate with your insurance plan (including Medicare):
Your Responsibility

- You must pay any co-payment at the time you receive the service.
- You must pay any deductible amount or any amount that you know is not covered at the time of service.
- You must pay the amount not paid by your insurance within 18 days of getting your bill.

Our Responsibility

- We will send a bill to your insurance company for all services done in our offices.

If we DO NOT participate with your insurance plan:
Your Responsibility

- You must pay for the service at the time it is given.
- We accept cash, VISA, MasterCard, Discover, money orders and bank drafts.

STATEMENT OF FINANCIAL RESPONSIBILITY

The patient who receives care and treatment from White Oak Psychiatric Associates must pay any charges that are not paid by insurance or any other party.

Other providers, such as laboratory, will bill the patient separately.

The patient must pay any amount not paid by insurance within 18 days of getting the bill. If White Oak Psychiatric Associates needs to use a collection agency or attorney to collect the unpaid amount, the patient may be charged for all fees and costs to White Oak Psychiatric Services by the agency or attorney.

ORGANIZATIONS FROM WHICH YOU MAY RECEIVE A BILL

White Oak Psychiatric Associates – Infinite Billing Solutions (816) 598-6000

White Oak Psychiatric Associates

Today's Date:

Patient Information – White Oak Psychiatric Services

Name_____ Sex: M or F Age _____

Address_____ Date of Birth _____

City, State Zip _____ Social Security _____

Patient Primary Number_____ Secondary Contact Number_____

Married, Separated, Widowed, Divorced, Single or Minor?_____

In case of an emergency who should be notified? _____ Phone_____

Patient Employer/School_____ Phone_____

Where did you hear about us? / Whom may we thank for referring you? _____

Primary Insurance

Person Responsible for Account_____ Date of Birth_____

Relation to Patient_____ Social Security Number_____

Address (if different than patient's)_____ Phone_____

City_____ State, Zip_____

Employer_____ Occupation_____

Employer Phone Number _____ Other Dependents Insured_____

Insurance Company_____ Subscriber ID_____

Group Number_____ Subscriber Number_____

Additional Insurance

Person Responsible for Account_____ Date of Birth_____

Relation to Patient_____ Social Security Number_____

Address (if different than patient's)_____ Phone_____

City_____ ***State, Zip_____***

Employer_____ ***Occupation_____***

Employer Phone Number _____ ***Other Dependents Insured_____***

Insurance Company_____ ***Subscriber ID _____***

Group Number_____ ***Subscriber Number_____***

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to White Oak Psychiatric Services all insurance benefit. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

White Oak Psychiatric Services may use my healthcare information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of Patient, Parent/Guardian, or Personal Representative

_____

Please Print Name of Patient, Parent/Guardian, or Personal Representative

_____ _____

Date ***Relationship to Patient***

HIPAA NOTICES OF PRIVACY PRACTICES

All specialists are required by law to maintain the privacy of your health information and provide you notice of our legal duties and privacy practices with respect to your health information. A copy of the WOPS privacy practices is available to you upon request.

_____ _____

(***Signature of Patient, Parent/Guardian, or Personal Representative)*** ***Date***

_____

Print Name

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

In order to protect your confidentially and to comply with government regulations (HIPAA). WOPS is required to obtain authorization from you in order to leave messages and/or provide information regarding your care with any person(s) other than you.

Please list any individual that we may release information regarding you, your mental treatment, and your history. It is not necessary to list physicians; only family members or friends.

_____ _____

Name ***Relationship***

_____ _____

Name ***Relationship***

_____ _____

Name ***Relationship***

I give consent to the physicians and staff of WOPS to leave messages or discuss scheduling, appointments, treatment, prescriptions, and other information regarding my care as follows:

Home Phone: Answering Machine or Voice mail	Circle	YES	NO
Cell Phone: Answering Machine or Voice mail	Circle	YES	NO
Work Phone: Answering Machine or Voice mail	Circle	YES	NO

YOUR RIGHTS AND RESPONSIBILITIES AS A CLIENT OF WHITE OAK PSYCHIATRIC ASSOCIATES

Welcome to White Oak Psychiatric Associates.
We hope that we can give you the kind of support and help that you are looking for.

When you receive services from White Oak Psychiatric Associates **you have the right to:**

- Receive high-quality service
- Be treated with respect and courtesy
- Have your information kept private and confidential except as described in White Oak Psychiatric Associates *privacy statement*
- Be listened to and have staff work with you to make a plan to address yourconcerns and needs
- Receive service in offices that are safe, clean and accessible
- Get information and support to help you make decisions to improve yoursituation
- Be served without discrimination
- Discuss your service with staff to identify if it is working for you and expressany questions or complaints that you may have
- Request a change of provider if there is another provider availablewho can address your issues and your request is reasonable -- you shouldknow that discriminatory requests will not be considered

This is what we ask from you:

- Treat the staff and others at White Oak Psychiatric Associates with courtesy and respect
- Let White Oak Psychiatric Associates staff know 24 hours before if you cannot come to an appointment.
- Let White Oak Psychiatric Associates staff know if you have any complaints or concerns.

Privacy Officer
The Privacy Officer for White Oak Psychiatric Associates is Alex Carpenter who can be contacted at 816 886 2184.

_____ _____

Signature of Patient, Parent/Guardian, or Personal Representative ***Date***

_____

Printed Name

PATIENT HEALTH HISTORY QUESTIONNAIRE

Primary Care Physician: _____ Phone #: _____ Fax #: _____

List All Prescriptions and over-the-counter medications, supplements and vitamins you take including the dose and strength:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies: _____

Latex Allergy: Yes / No

PAST MEDICAL HISTORY

Do you have now or have you ever had any of the following?

Heart Disease	Yes	No	Hyperthyroidism	Yes	No
Heart Attack	Yes	No	Kidney Stones	Yes	No
Heart Arrhythmia	Yes	No	Kidney Disease	Yes	No
Atrial Fibrillation	Yes	No	Stroke	Yes	No
Congestive Heart Failure	Yes	No	Gallbladder Disease	Yes	No
Hypertension	Yes	No	Anemia	Yes	No
Vascular Disease	Yes	No	Chronic Back Pain	Yes	No
Diabetes	Yes	No	Rheumatoid Arthritis	Yes	No
Insulin Dependent	Yes	No	Lyme Disease	Yes	No
High Cholesterol	Yes	No	Psoriasis	Yes	No
Lung Disease	Yes	No	Depression	Yes	No
Asthma	Yes	No	Osteoporosis	Yes	No
Reflux Disease (GERD)	Yes	No	Neuropathy	Yes	No
Ulcers	Yes	No	Hypothyroidism	Yes	No
Cancer (location) _____	Yes	No	Fibromyalgia	Yes	No
Blood Clots (DVT or PE)	Yes	No	Colitis	Yes	No

Other: _____

PAST SURGICAL HISTORY

Please list any operations you have had:

_____
_____
_____
_____
_____
_____

FAMILY/SOCIAL HISTORY

Occupation: _____

Your personal habits: Do you?

Exercise Regularly	Yes	No
Smoke or use Tobacco	Yes	No
How much _____		
For how many years _____		
Used tobacco in the past	Yes	No
Drink Alcohol	Yes	No
How much _____		
Recent Tick Bites	Yes	No

Do you have a family history of?			Relationship
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	_____
Diabetes	Yes	No	_____
Stroke	Yes	No	_____
Cancer	Yes	No	_____
Thyroid Disease	Yes	No	_____
Blood Clots	Yes	No	_____
Depression	Yes	No	_____
Anxiety	Yes	No	_____
ADHD	Yes	No	_____
Bipolar Disease	Yes	No	_____
Schizophrenia	Yes	No	_____
Autism	Yes	No	_____
OCD	Yes	No	_____
Tourette Syndrome	Yes	No	_____
Birth Defects	Yes	No	_____
SIDS, Sudden death	Yes	No	_____

REVIEW OF SYSTEMS

Have you recently been troubled with any of the following symptoms?

Backache	Yes	No	Bloody Sputum	Yes	No
Leg Pain	Yes	No	Indigestion	Yes	No
Painful Joints	Yes	No	Abdominal Pain	Yes	No
Headaches	Yes	No	Diarrhea	Yes	No
Double Vision	Yes	No	Constipation	Yes	No
Difficulty Swallowing	Yes	No	Change in Bowel Habits	Yes	No
Hoarseness	Yes	No	Slow Urine Stream	Yes	No
Nosebleeds	Yes	No	Abnormal Bleeding	Yes	No
Shortness of Breath	Yes	No	Blood in Stool	Yes	No
Dizziness	Yes	No	Pus in Urine	Yes	No
Chest Pain/Pressure	Yes	No	Yellow Jaundice	Yes	No
Irregular Heartbeat	Yes	No	Depression/Anxiety	Yes	No
Swelling of Feet	Yes	No	Weight Gain	Yes	No
Cough/Cold	Yes	No	How many pounds _____		
Wheezing	Yes	No	Weight Loss	Yes	No
Vomited Blood	Yes	No	How many pounds _____		
Sore throat	Yes	No	Fever	Yes	No
Rash	Yes	No	Dry Skin	Yes	No
Clammy skin	Yes	No	Palpitations	Yes	No
Cold/Heat intolerance	Yes	No			

MEDICATION PRIOR-AUTHORIZATIONS

Due to the overwhelming increase of medication prior authorizations from insurance companies, we require your assistance in the prior authorization process. One phone call, to attempt to complete a prior authorization, takes in excess of 30 minutes to complete. The volume of PA's we receive daily makes this an impossible task. For this reason, any medication for which your insurance company requires a prior authorization, we ask you to do either of the following:

1: **Cover My Meds**: Cover My Meds is the preferred method… Ask either your insurance company or pharmacy to send us the correct medication/insurance PA form through Cover My Meds. Upon arrival, we will complete the PA. This is the most efficient method and outcomes are generally received within the same day.

2: **Call our office**: Report to the office staff that your insurance company requires a PA. Ensure we have a copy of your correct insurance card and your pharmacy number. If we do not have the correct insurance card, email a correct copy to whiteoak@whiteoakpsych.com immediately.

Any medication that can be purchased using a Good RX card or other pharmacy discount card reducing the cost of the medication to $25.00 or less will be excluded from the PA process.

With your help, we can improve the timeliness of completing prior authorizations, ultimately getting your medications approved in the most efficient way possible.

MEDICATION REFILL REQUESTS

Most refills should be completed at the patient visit. In the event that you need a refill, we request you to call our office rather than the pharmacy. Refills that are required because you missed an appointment and failed to inform White Oak Psychiatric Services, will be assessed a $25.00 refill charge.

_____

I understand and agree to the above policies

_____

Print patient name