

THE PISGAH INSTITUTE FOR PSYCHOTHERAPY AND EDUCATION, P.A.

DOCTOR/CLINICIAN YOU WILL BE SEEING: _____ DATE BEING SEEN: _____

PATIENT INFORMATION

NAME _____
LAST FIRST MIDDLE PREFERRED NAME and/or PRONOUNS

DATE OF BIRTH: _____ S.S.N.: _____

GENDER PER YOUR INSURANCE: Female Male

If different gender identity, please specify: Transgender male(female to male) Transgender female(male to female)

Neither exclusively male nor female Other: _____ Prefer not to disclose

RACE: _____ DECLINED PRIMARY LANGUAGE: _____

MARITAL STATUS: SINGLE MARRIED SEPARATED DIVORCED WIDOW/WIDOWER DOMESTIC PARTNER

MAILING ADDRESS _____
CITY STATE ZIP

RESIDENCE ADDRESS _____
(IF DIFFERENT FROM MAILING ADDRESS)

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PREFERRED METHOD OF APPOINTMENT REMINDER CALLS (circle): CALL or TEXT and HOME#, WORK#, CELL#

EMAIL ADDRESS: _____

OCCUPATION _____ EMPLOYER _____

*DO YOU HAVE A LEGAL GUARDIAN? No If yes, NAME: _____

INSURANCE INFORMATION

*(If primary insured/card holder is **not the patient**, please complete INSURANCE INFORMATION section)*

Primary Insurance

PRIMARY CARDHOLDER'S NAME: _____ DOB: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE _____ CELL PHONE _____
CITY STATE ZIP

S.S.N.: _____ EMPLOYER'S NAME: _____

CARDHOLDER'S RELATIONSHIP TO PATIENT: SPOUSE PARENT OTHER: _____

Secondary Insurance

SECONDARY CARDHOLDER'S NAME: _____ DOB: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE _____ CELL PHONE _____
CITY STATE ZIP

S.S.N.: _____ EMPLOYER'S NAME: _____

CARDHOLDER'S RELATIONSHIP TO PATIENT: SPOUSE PARENT OTHER: _____

RESPONSIBLE PARTY FOR BILLING:

SELF OTHER (If "Other," please complete *RESPONSIBLE PARTY PAYMENT FORM*)

OUTSIDE CONTACT INFORMATION

PRIMARY CARE PHYSICIAN NAME: _____ ADDRESS: _____

IN CASE OF EMERGENCY, CONTACT: NAME: _____

PHONE: _____ RELATIONSHIP _____

REFERRING DOCTOR (if applicable): _____ ADDRESS: _____

PREFERRED PHARMACY (Name and Location): _____ Phone: _____

INSTRUCTIONS: Read the following carefully and initial each section that applies to you before signing below.

SELF-PAY

I have no insurance coverage or I am waiving the use of PRIVATE insurance. Therefore, I understand that I am responsible for payment of services rendered to myself or my dependents at the time of service.

(ONLY INITIAL HERE IF YOU DO NOT HAVE INSURANCE)>>>>>>>

Initial _____

INSURANCE AUTHORIZATION AND ASSIGNMENT

I hereby authorize the Pisgah Institute to release any information necessary to process insurance claims and request payments of benefits to be made to the Pisgah Institute for services rendered to myself or my dependents. I understand that I am responsible at the time of service for paying any required co-payment and deductible.

Initial _____

FINANCIAL AGREEMENT

I have read, understood, and signed the Patient Financial Agreement.

Initial _____

AUTHORIZATION AND CONSENT FOR TREATMENT

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I understand that I also have the right to refuse treatment by not initialing here and that refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option at our facility. G S 122C-57 I further understand that I have a right to treatment, including access to medical care and habilitation, regardless of age or degree of Mental Health/Intellectual Developmental Disability/Substance Abuse disability under G S 122C-51.

Initial _____

AUTHORIZATION FOR DISCLOSURE OF MY PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize the release of my protected health information to other clinicians involved in my treatment, except as I may indicate in the "Notice of Release of Initial Assessment to Referring Clinician" or in the "Request for Limitations and Restrictions of Sharing Protected Health Information (PHI)." The Pisgah Institute, P. A. has the right to refuse a request to limit disclosure of protected health information for this purpose, with limited exception.

Initial _____

MEDICAL RECORDS

While patients are entitled to access their medical records, I understand that requests are contingent upon the discretion of the patient's clinician(s) for approval of the medical record request and therefore, may take up to 30 days to process.

Initial _____

PRESCRIPTION MEDICATION HISTORY

I authorize the Pisgah Institute to request and use my prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

Initial _____

CRISIS COVERAGE

I understand that the Pisgah Institute has 24-hour coverage for behavioral health crises, and that I will always be able to reach someone at the main phone number.

Initial _____

PHOTOGRAPHS

I agree to have my photograph taken for identification purposes only, and I understand that it will not be used for any other purpose.

Initial _____

PROCESSING OF PRESCRIPTIONS

- **There is a 72-HOUR PROCESSING TIME for prescription requests, including refill requests. Requests for refills that are received after 12p.m. on Friday will not be called in until Monday. Patients should allow for this processing time.**
- **There is a \$15 or \$30 charge per prescription, including a refill, that is written, called in, or faxed outside of a scheduled appointment. To avoid this charge, please request refills during your scheduled appointment.**

Initial _____

*******I HAVE READ AND INITIALED EACH OF THE ABOVE AGREEMENTS, AND I UNDERSTAND MY RESPONSIBILITY AS A PATIENT/ LEGAL GUARDIAN. *******

SIGNATURE OF PATIENT/LEGAL GUARDIAN/RESPONSIBLE PARTY

Date _____

Bill Barley, Ph.D.
 Stephen E. Buie, M.D.
 Jeff Carter, M.D.
 Mary Berg, M.D.
 Susan Hill, Ed.D.
 Sarah Wells, M.D.

Danielle Mitchener, P.M.H.N.P.
 Nancy McKeel, Ph.D.
 Doug McKee, Psy.D.
 Elizabeth Rollins, M.D.
 Rita Christensen, Ph.D.
 Adam Hutchins, P.M.H.N.P.

John C. Donkervoet, Ph.D.
 Adena Altschul, Ph.D.
 Dorcas "Cassie" Miller, Ph.D.
 Keith Cox, Ph.D.
 Nicholas K. Ladd, D.O.
 L. Parks Harper, P.A.

Patient Financial Agreement

The management of mental health-benefits has become very complex and time consuming. We try to be accurate when informing you of your benefits, but as insurance companies clearly state, “**benefit information is not a guarantee of payment.**” Therefore, we cannot be certain of your account balance until after we receive payment from your insurance company.

- You are responsible for knowing whether your insurance covers the services of the provider you are seeing. To contact your insurance company about this, use the customer-service numbers on your insurance card, or ask your employer.
- Co-payments are due at the time of service. This is the **total** of what the insurance does not pay. If co-payments are not made, we may be unable to continue to provide service.
- **If your balance is over 30 days past due you should speak to the patient account coordinator.**
- Insurance policies are contracts between you and your insurance company. We file claims as a courtesy, but you are responsible for issues beyond our control. If your insurance does not pay within a reasonable time, you will be responsible for the full payment.
- We will file your secondary insurance as a courtesy. However, you will be responsible for what your primary insurance does not cover and/or what your secondary insurance does not pay in a timely way.
- If your provider is not covered by your insurance company, full payment is due when services are provided.
- Charges for phone consultations are not covered by insurance. Phone consultations are defined as phone calls made to/from the patient’s doctor or the doctor-on-call outside of a scheduled appointment and/or office hours.
- Prescriptions and refills are charged \$15-30 per prescription written, called in, or faxed, outside of a scheduled appointment.
- There are charges for missed appointments and late cancellations, which are any appointments cancelled less than 24 hours prior to the appointment start time.
- We will only retroactively file Medicaid charges three months from the date you give us your Medicaid card.
- Patients are responsible for their appointments. Reminder calls are a courtesy. Cancellations within 24 hours and no-shows may be charged for, and you will be responsible for the charge.

I have read and understand this agreement.

SIGNATURE

DATE

The Pisgah Institute
158 Zillicoa St.
Asheville, NC 28801

PLEASE READ BOTH NOTICES BELOW.

**Notice of Privacy Practices
Written Acknowledgement Form
(Copy upon request)**

I, _____, have been offered
a copy of The Pisgah's Institute's Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date

Notice of Release of Initial Assessment to Referring Clinician

I understand that if I have been referred to The Pisgah Institute by another health care provider, my initial evaluation will be sent to that referring provider upon completion.

I have the right to prevent this disclosure of my Protected Health Information by signing below. (*Sign ONLY if you do not wish your initial evaluation to be sent.*)

I DO NOT authorize this disclosure of information.

Signature of Patient or Legal Guardian

Date

The Pisgah Institute for Psychotherapy & Education, P.A.
Mental Health Authorization for Disclosure of Protected Health Information
(PHI)

This applies to: APPOINTMENTS ONLY

Patient Name: _____
Date of Birth: ____/____/____

I authorize The Pisgah Institute, P.A. and its employees to inform the following person(s) of my appointment time(s).

Person's name Relationship to patient
 I also authorize the person named above to make changes to my appointments.

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20____

Signature of Patient, Parent (for minor or child), Legal Guardian, Date
or Authorized Representative

This applies to: PRESCRIPTIONS ONLY

Patient Name: _____
Date of Birth: ____/____/____

I authorize The Pisgah Institute, P.A. and its employees to discuss prescription matters with the following person.

Person's name Relationship to patient

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon, and this authorization shall remain in force for one year or until (Date): _____, 20____

Signature of Patient, Parent (for minor or child), Legal Guardian, Date
or Authorized Representative

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D.L.F.A.P.A.

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Rita Christensen, Ph. D.

Adam Hutchins, P.M.H.N.P.

John Donkervoet, Ph.D.

Adena Altschul, Ph.D.

Doracs Miller, Ph.D.

Keith Cox, Ph.D.

Nicholas Ladd, D.O.

Parks Harper, P.A.

PATIENT REQUEST POLICIES

MEDICAL RECORDS

While patients are entitled to access their medical records, requests are contingent upon the discretion of the patient's clinician(s) for approval of a medical record request and, therefore, may take several days to process. Personal requests for medical records are also subject to charge based on number of pages processed.

PRESCRIPTION REQUESTS

There is a 72-hour processing time for prescription requests including refill requests. Requests for refills that are received after noon on Friday will not be processed until Monday. Patients should allow for this processing time and plan accordingly with their medications and appointments. **There may be a \$15 charge for filling prescriptions outside a scheduled appointment.** More complicated prescriptions, as as for a controlled substance, may result in a \$30 charge.

PAPERWORK REQUESTS (FORMS, LETTERS, ETC)

Providers are entitled to charge for any forms to be filled out, any letters requested to be written, or any other written/faxed request that will require time outside of a regularly scheduled appointment. These charges will be based on time spent and length of letter(s)/form(s).

PLEASE NOTE: These charges **are the responsibility of the patient** and will **NOT** be billed to insurance. If you have any questions regarding these charges, please feel free to discuss them with your provider. Thank you.

Patient Name (please print)

Date

Signature (of patient or authorized representative)

Relationship to Patient

WELCOME TO THE PISGAH INSTITUTE

Informed Consent

Welcome to The Pisgah Institute! We are licensed by the State of North Carolina as physicians, psychologists, psychiatric nurse practitioners, and physician assistants. We provide medication management as well as individual, couples, family, and group psychotherapy. Additionally, we provide psychological testing and transcranial magnetic stimulation.

What to Expect From Treatment

Your needs are not like everybody else's. Some patients will need only a few appointments to reach their goals and feel better. Other patients may need many sessions. Sometimes people feel worse before they see progress and feel better. In any case, psychiatric and psychological treatment is an active process which is more successful the more actively engaged you are with it. That means coming on time and regularly to your appointments. Many patients note improved feeling and functioning, including improved relationships, after they have participated in treatment. However, it is impossible to provide such guarantees. You are the consumer of these services, and your input about them is very important, including about when they are no longer needed.

Frequently Asked Questions

What will my first appointment be like? Your first appointment will be an initial evaluation in which you describe your current situation and symptoms. You may be asked questions about your personal, family, and health background as well. Toward the end of your first appointment, a tentative treatment plan going forward will be discussed. You will also be assessing whether or not the provider you are meeting with is a good fit for you. If not, we can help you find someone who may be a better fit.

How is confidentiality handled? With few exceptions, your personal information will be held in confidence. We will disclose confidential information when you have given us written consent to do so; when the law mandates the disclosure; and/or when the law gives us the discretion to disclose. In some situations, we may need to release some kinds of personal information to secure needed professional services for you; obtain appropriate professional consultations; protect you and/or others from harm; or obtain payment for services. We follow federal and state laws as well as professional ethical guidelines when handling confidential information.

What is an emergency? If you have an unusual physical or emotional reaction to your medications or have suicidal or homicidal thoughts, please call the office to talk to your clinician or the clinician on call. After hours, you can reach the provider on call through our general number (828-254-9494) and answering service.

What if I have a crisis and want to be seen right away? We respect the fact that people in crisis may need attention quickly, but immediate appointments may not always be available. If you find yourself in urgent need of an appointment, please call us to see when and how we may accommodate you. We will do our best to respond quickly to your needs.

Will I be charged for an emergency call? We prefer not to charge for phone calls, because we like to encourage an open line of communication. However, depending on the complexity of the issue, you may be charged.

What do I do if I have paperwork to be completed? We understand and respect the fact that various forms and documents must be filled out. We take these requests seriously and respond to them in a timely fashion outside of your appointments. You could be charged a fee ranging from \$25-75 for filling these forms out.

How may I leave a message for you? We have a confidential voice mail, and you may leave messages there. You can be as detailed as you need to be. Please leave a phone number where you can be reached. You can also reach your clinician through the Patient Portal, which is safe and secure. Please give us your email so we may invite you to join the Patient Portal.

Can I be seen downstairs? Yes, you may, with prior notice.

Can I communicate by email, fax, text, or social media? Confidentiality of any of these modes of communication cannot be guaranteed. In the interest of confidentiality, we do not use any of these methods of communication.

What do I do if there is bad weather and the roads are bad? We encourage you to use your judgment about the safety of driving during inclement weather. First check WLOS, our Facebook page, and our website to see if we are closed. You can also call our office. When you have to cancel an appointment because of the weather, the late-cancellation fee will be waived.

Can I be dismissed from the practice? You can be dismissed from the practice for excessive late-cancelled or no-show appointments as well as non-payment of your bill. This will vary per clinician. However, once you have been dismissed, it is unlikely you will be reassigned to another provider in our practice.

Thank you for your kind attention to this information! We hope that it will help you get the most out of your treatment here. Please sign the bottom and return. Thank you again for choosing The Pisgah Institute.

Signature

Date