WHITE OAK
Psychiatric Services

New Patient Registration Information

FINANCIAL POLICY

White Oak Psychiatric Services 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 to 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 Services 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 Services 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 Services must pay any charges that are not paid by insurance or any other party.

Other providers, such as the 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 Services 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 Services

Patient Information – White Oak Psychiatric Services

Today's Date: _____ Email _____

Name_____ Sex: M or F Age _____

Address_____ Date of Birth _____

City, State Zip _____ Social Security _____

Patient Primary 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 _____ Phone _____

Insurance Company _____ Subscriber ID _____

Group Number _____

Additional Insurance

Person Responsible for Account _____ Date of Birth _____

Relation to Patient _____ Phone _____

Insurance Company _____ Subscriber ID _____

Group 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***

FOR PATIENTS WITHOUT INSURANCE

ACKNOWLEDGMENT OF SELF-PAY STATUS PATIENT RESPONSIBILITY

Dear Patient,

You are being provided this letter of acknowledgement because you have requested that your doctor visit today be coded as "self-pay" and that you receive a "self-pay discount." A self-pay discount is offered to patients who elect to pay for the service in full on the date of service and who will not be submitting the claim to an insurance carrier. You have requested that this service be coded as self-pay because (**initial one**):

____ You have no health insurance.

____ You have health insurance, but you do not want your insurance billed and instead want to pay out of pocket.

____ Other (please explain): _____

We want you to know what to expect so that you can make an informed decision. In order to accomplish this, by signing below you agree to the following:

- All fees for the self-pay service must be paid on the date of service.
- The self-pay amount covers only the professional services provided by your physician. You are financially responsible for all medication fees as White Oak will not process medication prior authorizations.
- If you have insurance or other types of coverage, services received today that are included in the "self-pay" discount will not likely be reimbursed by your carrier or applied to your deductible. You may want to discuss this with your insurance carrier before agreeing to the self-pay discount.

By my signature below, I acknowledge that I have read and understand the above and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative.

Patient or Representative Name _____ Date _____

If signed by someone other than the patient, please specify relationship to the patient: _____

Patient or Representative Signature _____ Date _____

HIPAA NOTICES OF PRIVACY PRACTICES

All specialists are required by law to maintain the privacy of your health information and provide you with 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.

_____ _____

Patient Signature Date

_____

Print Name

PATIENT CONSENT FOR RELEASE OF MEDICAL INFORMATION

In order to protect your confidentiality 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
Consent to obtain Medication History	Circle	YES	NO
Consent to share data with Health Information Exchange	Circle	YES	NO

Health Information Exchange allows health care professionals and
patients to appropriately access and
securely share a patient's medical information electronically

I am aware that video only (no audio) cameras are installed in rooms for provider and patient security.

_____

Signature

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

Welcome to White Oak Psychiatric Services.
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 Services 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 Services *privacy statement*
- Be listened to and have staff work with you to make a plan to address your concerns and needs
- Receive service in offices that are safe, clean, and accessible
- Get information and support to help you make decisions to improve your situation
- Be served without discrimination
- Discuss your service with staff to identify if it is working for you and express any questions or complaints that you may have
- Request a change of provider if there is another provider available who can address your issues and your request is reasonable -- you should know that discriminatory requests will not be considered

This is what we ask from you:

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

_____ _____

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

_____

Printed Name

PATIENT HEALTH HISTORY QUESTIONNAIRE

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

Previous Psychiatrist: _____ Phone #: _____ Fax #: _____

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

_____ _____

_____ _____

_____ _____

List all previously tried medication and reason for no longer taking it:

_____ _____

_____ _____

_____ _____

Allergies: _____

Current Pharmacy: _____ Address: _____ Phone: _____

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

Other: _____

_____

FAMILY/SOCIAL HISTORY

Your personal habits: Do you?

Exercise Regularly	Yes	No	Circle One	Circle One
Smoke/Vape or use tobacco	Yes	No	Tobacco (Smoke/Chew)	Vape (Nicotine/Cannabis/CBD/Flavors)
How many times a day: _____				
Started Use: _____	Last Used: _____			
Used tobacco in the past	Yes	No		
Last Used: _____				
Use CBD (Liquid or Edible)	Yes	No		
Have exposure to secondary smoke	Yes	No		
Drink Alcohol	Yes	No		
How much _____				
Recent Tick Bites	Yes	No		

Do you have a family history of?			Relationship	Maternal/Paternal	Medication for Condition
Depression	Yes	No	_____	_____	_____
Suicide Attempts	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	_____	_____	_____
Substance Use	Yes	No	_____	_____	
• Smoker	Yes	No	_____	_____	
• Alcohol	Yes	No	_____	_____	
• Cannabis	Yes	No	_____	_____	
• CBD	Yes	No	_____	_____	
Other Substance Name: _____			_____	_____	
Birth Defects	Yes	No	_____	_____	
SIDS, Sudden death	Yes	No	_____	_____	
Heart Attacks	Yes	No	_____	_____	
Pacemaker	Yes	No	_____	_____	
Early Death	Yes	No	_____	_____	
Down's Syndrome	Yes	No	_____	_____	
Genetic Disorder	Yes	No	_____	_____	
Miscarriage	Yes	No	_____	_____	
Thyroid Disease	Yes	No	_____	_____	
Blood Clots	Yes	No	_____	_____	
Sleep Apnea	Yes	No	_____	_____	

Do you have a family history of?			Relationship	Maternal/Paternal
Heart Disease	Yes	No	_____	_____
High Blood Pressure	Yes	No	_____	_____
Diabetes	Yes	No	_____	_____
High Cholesterol	Yes	No	_____	_____
Stroke	Yes	No	_____	_____
Cancer	Yes	No	_____	_____
Other	Yes	No	_____	_____

PAST SURGICAL HISTORY

Please list any operations you have had:

_____
_____
_____
_____
_____
_____

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
(PLEASE READ)

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: **CoverMyMeds**: CoverMyMeds is the preferred method. Ask either your insurance company or pharmacy to send us the correct medication/insurance PA form through CoverMyMeds. 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's visit. In the event that you need a refill, we request you to email our office at meds@whiteoakpsych.com rather than the pharmacy. Refills that are required because you failed to schedule an appointment or you missed an appointment and failed to inform White Oak Psychiatric Services will be assessed a $50.00 refill charge.

_____

I understand and agree to the above policies

_____

Print patient name

MEDICATION PRIOR-AUTHORIZATIONS
PLEASE KEEP FOR YOUR RECORDS

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:

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Answer if you are **under** 18 years old and have ever smoked.

The HONC

	No	Yes
1. Have you ever tried to quit but could not?		
2. Do you smoke now because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to?		
When you have not used tobacco for a while or when you tried to stop smoking		
7. Did you find it hard to concentrate because you could not smoke?		
8. Did you feel more irritable because you could not smoke?		
9. Did you feel a strong need or urge to smoke?		
10. Did you feel nervous, restless, or anxious because you could not smoke?		

Answer if you are <u>18 or over</u> and are a current smoker

The Fagerstrom Test for Nicotine Dependence

Questions	Answers	Points
1. How soon after you wake up do you smoke your first cigarette?	Within 5 minutes	3
	6-30 minutes	2
	31-60 minutes	1
	After 60 minutes	0
2. Do you find it difficult to refrain from smoking in places where it is forbidden? (e.g., in church, at the library, in cinema, etc.)	Yes	1
	No	0
3. Which cigarette would you hate most to give up?	The first one in the AM	1
	All others	0
4. How many cigarettes per day do you smoke?	10 or less	0
	10 to 20	1
	21 to 30	2
	31 or more	3
5. Do you smoke more frequently during the first hours after waking than during the rest of the day?	Yes	1
	No	0
6. Do you smoke if you are so ill that you are in bed most of the day?	Yes	1
	No	0

Office Use Only Total _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

Total Score: _____

If you circled any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) =

8-9 oz. of malt liquor (about 7% alcohol) =

5 oz. of wine (about 12% alcohol) =

1.5 oz. of hard liquor (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

Why fill out a Release of Information?

By filling out the release of information form located on the back of this page, you authorize White Oak Psychiatric Services to obtain any prior medical information.

Exchange of health information is an essential function to the provision of high-quality and cost-effective healthcare. When providing White Oak Psychiatric Services with authorization to obtain medical information, you assist your provider in getting more details about your mental or physical health.

In the case that an insurance provider requires prior authorization for a medication, obtaining previous medical records will aid our office to determine any prior medication trials or failures. This is essential to expedite the process of prior authorizations.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

A valid street mailing address is required in order to send records.

☐ Receive from: _____

_____
Fax Number

I hereby authorize:

White Oak Psychiatric Services
4045 NE Lakewood Way, Ste 130
Lee's Summit, MO 64064
Fax: 816-886-2397

☐ Disclose to: _____
Address: _____
_____
_____
Fax Number

The following information regarding my outpatient care on _____
Specify dates of clinic visits

Please Check

- ☐ Complete Medical Records
- ☐ Complete Mental Health Records
- ☐ Hospital Discharge Summary
- ☐ Consultations
- ☐ History and Physical Examinations
- ☐ Records from Other Providers (please specify) _____
- ☐ Other (please specify _____
- ☐ X-Ray, Imaging Reports
- ☐ Laboratory Reports
- ☐ Cardiac/EKG Reports

The purpose for disclosing the above information is indicated by a check mark below:

☐ Continuing Care ☐ Relocation ☐ Insurance ☐ Legal ☐ Other _____

I understand that I have no obligation to disclose information from my records and that I may revoke this authorization by submitting a request in writing along with a copy of this form to the Practice manager of this office. I understand that any action already taken in reliance on this authorization cannot be reversed and my revocation will not affect those actions.

The signing of this authorization is not a condition for providing treatment.

I understand that if the organization authorized to receive the information is not a health plan or health care Provider; the information may be re-disclosed and no longer be protected by federal privacy regulations. However, certain protected records such as drug and/or alcohol use, abuse, treatment, or referrals for treatment, HIV information; and mental health services may not be re-disclosed per state laws and regulations and/or Federal confidentiality rules.

My signature acknowledges that I have read and understand the contents of this authorization and voluntarily consent to the release of information as stated including release of any records identified below unless I check here to not disclose such records. Checking or not checking the box is no indication that such information exists. Records **NOT** to disclose:

☐ HIV information ☐ Mental health services ☐ Drug and/or alcohol use, abuse, treatment, or referrals for treatment.

My signature also acknowledges receiving a copy of the document.

THIS AUTHORIZATION SHALL EXPIRE 12 MONTHS FROM THE DATE EXECUTED UNLESS OTHERWISE SPECIFIED BY THE PATIENT:

_____	_____	_____
Print Patient's Full Name	Signature of Patient/Responsible Party	Date
_____	_____	
Patient's Date of Birth	Relationship to Patient	
_____	_____	_____
Patient's Social Security Number	Witness Signature	Date

NOTE: This authorization will not be accepted unless it is completed in its entirety.