WHITE OAK
Psychiatric Services

New Patient Registration Information
PARENT PACKET

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 _____

Legal Name _____ Sex: M or F Date of Birth _____

Preferred Name (If different than legal name) _____ Social Security _____

Address _____ City, State Zip _____

Primary Number (Cell Phone/Home Phone)_____ Relation (If not the patient) _____

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

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***

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.

_____ _____

(***Signature of Patient, Parent/Guardian, or Personal Representative)*** ***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
Work Phone: Answering Machine or Voice mail	Circle	YES	NO

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: _____

_____

SCHOOL/SOCIAL HISTORY

School Name: _____ Grade: _____

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)
If Yes				
How many times a day: _____				
Started Use: _____ Last Used: _____				
Used Marijuana	Yes	No		
If Yes				
Started Use: _____ Last Used: _____				
Use CBD (Liquid or Edible)	Yes	No		
Have exposure to secondary smoke	Yes	No		
Drink Alcohol	Yes	No		
How many times a week: _____				
Started Drinking: _____ Last Drink: _____				
Recent Tick Bites	Yes	No		

Do you have a family history of? Includes Parents, Siblings, Grandparents, Aunts, Uncles, Cousins, Etc.			Relationship	Maternal/Paternal (M/P)	Medication for Condition
Depression	Yes	No	_____	_____	_____
Suicide Attempts	Yes	No	_____	_____	_____
Anxiety	Yes	No	_____	_____	_____
ADHD	Yes	No	_____	_____	_____
Other Learning Disorder	Yes	No			
Please Specify: _____			_____	_____	_____
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	Yes	No	_____	_____	

			Relationship	Maternal/Paternal (M/P)
Dementia	Yes	No	_____	_____
Movement Disorder	Yes	No	_____	_____
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	_____	_____
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	_____	_____
Please Specify: _____			_____	_____
_____			_____	_____
_____			_____	_____

PAST SURGICAL HISTORY

Please list any operations you have had:

_____
_____
_____
_____
_____
_____

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

KEEP FOR YOUR RECORDS

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