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 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
☐	☐	☐	☐