STRAND PSYCHIATRIC ASSOCIATES, P.A.

Diplomates, American Board of Psychiatry and Neurology

MURRAY GLENN HONICK, M.D.
Child, Adolescent & Adult Psychiatry

RENEE RUTH LAMM, M.D.
Addiction Medicine & Psychiatry
Fellow, American Academy of Family Practice

Consent to Use and Disclose Your Health Information

This form is between you, _____ and Strand Psychiatric Associates, P.A. The word "you", as used below, will mean your child, relative, or other person if you have written his or her name here.
_____

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected health Information (PHI) about you. It is necessary to use this information here to decide which treatment is best for you and to provide treatment to you. We may also share this information with others who provide treatment to you or need it to arrange payment for your treatment or for other business or government functions.

By signing this form, you are agreeing to let us use your information here and send it to others. The Notice of Privacy Practice explains in more detail your rights and how we can use and share your information. Please read this before you sign this consent form.

If you do not sign this consent form agreeing to what is in our Notice of Privacy Practices, we can not treat you.

In the future, we may change how your information is used and shared and so may change our Notice of Privacy Practices. If changed, you may get a copy from our privacy officer. If you have any questions regarding our Privacy Notice or our Health Information Privacy Policies, please contact our Privacy Officer who is Kathryn Worrell, Office Manager for Strand Psychiatric Associates, PA and may be contacted at (843) 215-2400.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment or administrative purposes. You will have to tell use what you want in writing. Although we will try to respect your wishes, we are not required to agree to these limitations. However, if we do agree, we promise to comply with your wish.

After you have signed this consent form, you have the right to revoke it by writing a letter telling us that you no longer consent. We will comply with your wishes about using or sharing your information from that time on, except to the extent that Strand Psychiatric Associates has already taken action in reliance thereon which cannot be revoked.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/ Legal Guardian Date

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FINANCIAL INFORMATION & OFFICE POLICIES

FULL PAYMENT IS DUE AT THE TIME OF SERVICE unless prior arrangements are made.

WE ACCEPT CASH, CHECK, VISA, MASTERCARD & DISCOVER

REGARDING INSURANCE:

Your insurance policy is a contract between you and your insurance company. **We are not party to that contract.** In the event we do accept assignment of benefits, it is the patient's responsibility to acquire preauthorization if needed and also to pay any deductible and co-pay applicable.

Medicare No:_____ Effective Date:_____
Medicaid Number:_____ Effective Date:_____
Insurance Company:_____ Policy No:_____

*A copy of your insurance card is required at the time of visit if we are filing your insurance.

**There will be a charge of the full fee amount of the scheduled appointment for all No-Shows and Canceling less than 24-hours in advance.

**There will be a $30.00 service charge for any returned checks.

**There will be at least a $25.00 charge for the completion of any forms including insurance forms, disability forms, waiver premium forms, appeals and prior authorizations.

Assignment of Insurance Benefits: I hereby assign to and authorize payment directly to S.P.A., of all benefits payable under the terms of Medicare, Medicaid or any Insurance policy or benefits listed above. (Not applicable when payment is made)

Financial Responsibility: I understand that I am financially responsible to S.P. A., for all legal charges incurred by the person(s) named above. In the event that this account is placed in the hands of an agency or attorney for collection, the patient and/or grantor, jointly and severally, agree to pay all costs of collection which include but are not limited to interest at the highest legal rate, agency/attorney fees, and court costs.

_____ _____
Signature of Patient or Responsible Party Date Signature of Witness or Staff

SYMPTOMS LIST: **Check off any of these symptoms which have been most bothersome or have occurred frequently during the last 4 weeks.**

GENERAL SYMPTOMS

- ❑ Fever
- ❑ Repetitive, senseless thoughts
- ❑ Repetitive, senseless behaviors
- ❑ Fainting or feeling faint
- ❑ Tremors, trembling, or shakiness
- ❑ Seizures
- ❑ Easy bruising
- ❑ Skin rash
- ❑ Violent behavior
- ❑ Constant worry
- ❑ Irritability
- ❑ Tension
- ❑ Headache
- ❑ Feeling in a dreamlike state
- ❑ Fearful feelings
- ❑ Fear of losing control
- ❑ Jumpiness
- ❑ Restlessness
- ❑ Sweating
- ❑ Dizziness/lightheadedness
- ❑ Keyed up/on edge
- ❑ Agitation
- ❑ Nervousness
- ❑ Trouble concentrating
- ❑ Insomnia/trouble sleeping
- ❑ Decrease in sex drive
- ❑ Trouble making decisions
- ❑ Sad/depressed/down in the dumps
- ❑ Lack of/loss of interest in things
- ❑ Helpless feelings
- ❑ Fatigue–lack of energy
- ❑ Weakness
- ❑ Increase or decrease in appetite
- ❑ Increase or decrease in weight
- ❑ Frequent crying or weeping
- ❑ Frequent thoughts of death or suicide
- ❑ Worthless feelings
- ❑ Excessive feelings of guilt
- ❑ Hopeless feelings
- ❑ Feeling life is not worth living
- ❑ Sleeping too much
- ❑ Frequent negative thinking
- ❑ Memory problems
- ❑ Fear of doing something uncontrollable
- ❑ Fear of dying
- ❑ Chills
- ❑ Seeing or hearing things that are not real
- ❑ Fear of going crazy

FOCUS™

Well-Being Chart

Name _____

❑ Male ❑ Female Age _____ Today's Date _____

Instructions: *This Well-Being Chart is a confidential document between you and your doctor. It is intended to help you and your doctor discuss your well-being openly and candidly. Your doctor may ask you more questions about some of these items to pinpoint problems you may have. Please answer each question in the space provided.*

Have you taken any medications in the last 4 weeks? ❑ Yes ❑ No

If yes, please list: _____

Do you smoke cigarettes? ❑ Yes ❑ No

EYES AND EARS

- ❑ Double vision
- ❑ Difficulty in focusing vision
- ❑ Eye pain
- ❑ Sinus pain
- ❑ Increase or decrease in tearing

CARDIOVASCULAR

- ❑ Chest pain
- ❑ Chest discomfort
- ❑ Heart pounding

GASTROINTESTINAL

- ❑ Diarrhea
- ❑ Constipation
- ❑ Heartburn
- ❑ Rectal bleeding
- ❑ Black, tarry stools
- ❑ Stomach pain
- ❑ Food intolerance
- ❑ Abdominal bloating

RESPIRATORY/NOSE/ THROAT/MOUTH

- ❑ Cold (influenza)
- ❑ Nasal congestion
- ❑ Nosebleeds
- ❑ Hay fever
- ❑ Cough
- ❑ Wheezing
- ❑ Shortness of breath
- ❑ Pain when breathing

URINARY

- ❑ Frequent urination
- ❑ Painful urination
- ❑ Difficulty in passing urine
- ❑ Blood in urine

OTHER SYMPTOMS NOT LISTED ABOVE – PLEASE SPECIFY:

_____

_____

_____

_____

_____

_____

_____

MEDICAL DISCLAIMER: This chart is intended as a screening device to assist you in informing your doctor about your medical condition. Bristol-Myers Squibb advises the patient to check with a physician before beginning any program which impacts your well-being. This chart does not take the place of your physician's recommendations, and Bristol-Myers Squibb takes no responsibility for consequences from the use of this chart.

Office comments:

_____

_____

_____

A D w/A D

(Circle any that apply)

THIS AREA FOR OFFICE USE ONLY

A complete evaluation is necessary to establish a diagnosis.

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Prescription Policies & Guidelines

Refill requests will only be processed when initiated by the patient through our prescription hotline. To reach the prescription hotline, dial 843-215-2400 option 1.

General Refill Guidelines

- Patients MUST have a follow-up appointment scheduled before requesting a prescription refill.
- Prescription refills have a processing time of two business days. Please make sure to place your refill request with this in mind.
- Refill requests are processed Monday-Thursday. We do NOT process prescription refills on Friday.
- Do not call back to check the status of your refill request. If we do not call you with an issue, your refill should arrive at your pharmacy within two business days.
- Be prepared to provide the full street address to your pharmacy when leaving a refill request

Initial _____

Prescription Refill Policies

- Patients should **rarely** need to call for prescription refills, as your provider will write enough medication to last until your next appointment

- Possible Exceptions:

1. Some medications are required by law to prescribe a 30-day supply at one time; however, your provider may prescribe three separate months of medication at their discretion
2. When trying a new medication for the first time, your provider may only write a 30-day supply to see how you respond to the medication.
3. When there is an issue with a current medication

Initial _____

Medication Prior Authorizations

Insurance companies frequently require prior authorization before they will pay for certain medications

- Prior authorizations are time-consuming, as they involve paperwork, medical records, and commentary from your provider. Thus, prior authorizations may take up to 72 hours. If it is denied, an appeal can take up to 30 days
- Prior authorizations have a fee of $20, and $25 if an appeal is necessary
- Once your medication is rejected at your pharmacy, the patient or pharmacy must initiate the prior authorization request
- Please make sure we have your recent insurance cards on file to avoid delay in the prior authorization process
- If you do not wish to pay for prior authorizations, we can put a note on your account per your request stating that your provider must choose low-cost or covered alternatives instead of obtaining prior authorization

Initial _____

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PATIENT INFORMATION

First Name:_____ M.I:____ Last:_____
Address:_____
City:_____ State:_____Zipcode:_____
Sex:_____ Date of Birth:_____ Social Security Number:_____
Race:_____ Marital Status:_____
Home Phone:_____ Work Phone:_____ Emg. Phone_____
Employer:_____ Employer's Address:_____
Next of Kin:_____ Address & Phone #:_____
Referring Physician:_____
Current Medical Problems:_____
Medications and Dosages:_____
Drug Allergies/ Reactions:_____

RESPONSIBLE PARTY INFORMATION

First Name:_____ M.I:____ Last:_____
Relationship to the Patient:_____ Social Security Number:_____
Address:_____
City:_____ State:_____ Zipcode:_____
Home Phone:_____ Work Phone:_____
Employer:_____ Employer's Address:_____

CONSENT FOR PARTICIPATION IN TREATMENT

On behalf of myself, or the patient if a minor, I hereby consent and agree to the following conditions of participation in assessment and treatment:

1. VOLUNTARY PARTICIPATION: I voluntarily consent to participate in such psychiatric care and counseling services as may be deemed necessary and appropriate by the physician and/or clinical staff of S.P.A. I understand that I will be kept informed of plans for my treatment and may withdraw my consent at any time. I am aware that the practice of medicine and counseling are not exact sciences and acknowledge that no guarantees have been made to me as to the examinations and treatments.

2. DESTRUCTION OF PROPERTY: I understand that patients are responsible for any damage or destruction of S.P.A.'s property, belonging to others which may be located at S.P.A., and I agree to accept liability for and reimburse S.P.A. or other owners of property which I may damage or destroy.

3. CONFIDENTIALITY: Verbal or written information regarding my treatment may be released only with my specific written consent, (or by court order, or when in the opinion of S.P.A.'s staff that I am in a crisis situation and release of information would be for the safety and protection of myself and/or others).

4. FOLLOW-UP: I agree that S.P.A.'s staff members may call or write if I fail to keep an appointment in order to assess my need for further treatment.

CONFIDENTIAL STATEMENT

I agree as a visitor to Strand Psychiatric Associates to maintain confidentiality regarding the patients and respect their right to privacy. I understand that should I reveal the identity of any patients, discuss any medical information or other information that violates the privacy right of the patients within this facility it could result in legal action against me. By my signature below I accept responsibility for maintaining this confidentiality.

_____ _____ _____
Signature of Patient or Responsible Party Date Signature of Witness or Staff

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Patient Information
Office Hours: 9:00am-5:00pm Monday –Thursday
9:00am-12:00pm Friday
Closed – Weekends

* We Accept payments in the form of Cash, Check, Visa, Master card or Discover

Telephone Call Policy: Please note that we do not have a live telephone line. You must always leave a message.

Please call during office hours to make, cancel or change an appointment, request a refill on medication or leave messages for physicians. Do not leave these requests on after hours line.

_____
Initial

- Dr. Honick returns phone calls during the day between appointments as time permits. Dr. Lamm returns calls after hours only, usually after 6:00pm.

Afterhours Call Policy: This line is for emergency calls only such as a medical reaction to medication or a life threatening situation. Please speak clearly and leave detailed information so that we can contact you.

_____
Initial

No Show and Cancellation Policy: There is **a full fee** charge for no show and appointments cancelled on the same day. You must give 24 hour notice to avoid a full fee charge when cancelling appointments.

_____
Initial

Thank you for your consideration and cooperation.

_____ _____ _____
Signature of Responsible Party Date Signature of Witness