New Patient Packet

FreeState
PRIMARY CARE

Hello,

Welcome to Free State Primary Care. We are looking forward to providing you with mental health services. Please fill out the forms in this New Patient Packet. The packet must be returned prior to your scheduled appointment, or your appointment will be canceled.

IMPORTANT: In order to fill out this PDF, download it to your computer, fill it out, and save it using Adobe Acrobat Reader. You will not be able to save the document if filled out in a browser window. If you do not have Acrobat Reader here is a link to download it for free: **https://acrobat.adobe.com/us/en/products/pdf-reader.html**

Or if you prefer, you can print, fill out with pen, upload, and send back via email or fax.

We are happy you chose us to be your mental health provider.

Sincerely,
MELISSA WARD CRNP
Free State Primary Care

741 Annapolis Road
Gambrills, MD 21054

P 240.647.9049
F 240.690.6095

info@freestatehw.com
freestatehw.com

FreeState PRIMARY CARE

PATIENT REGISTRATION FORM

PATIENT INFORMATION

FIRST NAME | LAST NAME

DOB | SSN

ADDRESS

PHONE

Home ☐ Cell ☐ Work ☐ Ok to leave a voicemail? Yes ☐ No ☐ Ok to text message? Yes ☐ No ☐

EMAIL

RELATIONSHIP STATUS Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed ☐

GENDER Female ☐ Male ☐ Other ☐

EMERGENCY CONTACT

NAME | RELATIONSHIP TO PATIENT | PHONE

INSURANCE INFORMATION

INSURANCE COMPANY | ID NUMBER | POLICY NUMBER

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY | ID NUMBER | POLICY NUMBER

FreeState
PRIMARY CARE

PATIENT REGISTRATION FORM

POLICY HOLDER INFORMATION

FIRST NAME LAST NAME

DOB SSN

ADDRESS PHONE

PARENT/GUARDIAN #1

GENDER Female ☐ Male ☐ Other ☐

NAME DOB

RELATIONSHIP TO PATIENT SSN

ADDRESS PHONE

EMAIL

PARENT/GUARDIAN #2

GENDER Female ☐ Male ☐ Other ☐

NAME DOB

RELATIONSHIP TO PATIENT SSN

ADDRESS PHONE

EMAIL

FreeState
PRIMARY CARE

INSURANCE POLICY

INSURANCE

- Insurance Cards are required at every visit. We will verify your insurance coverage at the time of your first visit if possible.
- Depending on your insurance, Free State Primary Care, LLC. will be reimbursed based on a percentage of the amount billed. We do not know the exact amount until we receive payment. All co-payments, deductibles, and payments for non-covered services are due at the time of the service or when balances become known. As the recipient of services, you are ultimately responsible for all services provided. Not all services may be covered by insurance, and you will be fully responsible for those uncovered charges. Free State Primary Care, LLC, is under no obligation to pursue reimbursement on the patient's behalf.
- If payment from your Insurance Provider is not received in full within thirty (30) days after submission of the request for payment, it is your responsibility to pay. If payment is not received in full within sixty (60) days, by providing your credit card and receiving provided services, you are authorizing Free State Primary Care, LLC. to charge your provided credit card for any unpaid bills or claims. Without a card on file, payment is due in full at the time services are rendered. Any claims paid after your credit card has been billed will be refunded to you.

If you are covered by accepted Insurance plans:

- It is your responsibility to contact your insurance carrier to discuss your plan's mental health benefits, including any deductibles, co-payments, annual and lifetime limits, and if pre-authorization is required. We will bill the carrier for you.
- Your co-pay is due at the time of service.
- You are responsible for all charges not paid by your insurance, including deductibles, co-payments, any uncovered charges, charges for missed appointments, etc.
- You are responsible for informing the front desk of any changes to your insurance coverage.

If you are covered by an Out of Network Provider Plan:

- The out of pocket payment is **due at the time of service.**
- After payment has been made and applied towards the billed services, we will provide you with an Insurance Invoice to submit to your insurance plan.

SIGNATURE

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above mentioned Health Insurance Providers, and hereby assign and convey directly to Free State Primary Care, LCC, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments.

PATIENT/GUARDIAN SIGNATURE DATE

FreeState
PRIMARY CARE

BILLING POLICY

ACKNOWLEDGMENT OF BILLING POLICY

- Payment is due at the time of service.
- Payment may be made by Cash, Check or Credit Card.
- You must provide a credit card number to be kept on file. In the event that a balance is outstanding more than 60 days, this card will be automatically charged.
- Once an account is more than 90 days past due, it is subject to Collections action.
- The fees for the Initial Evaluation and subsequent sessions are as discussed at intake or with your clinician.
- Statements for outstanding balances are generated monthly.
- If your check is returned NSF (non-sufficient funds), a $30 charge will be added to the outstanding balance.
- It is your responsibility to provide the office with up-to-date billing information, including changes to address, credit card, and Insurance information.
- Free State Primary Care, LLC, will only bill directly to our Contracted Provider Plans.

CANCELLATION POLICY

At least 24 business hours' notice of cancellation is required to avoid being charged the cancellation fee. If you do not cancel your appointment within the 24 business hour requirement, you will be charged the **FULL FEE** ($200, $150 OR $125 depending on the type of appointment and provider) **Cancellation fees cannot be billed to Insurance.**

SIGNATURE

I have read the above information and agree with these conditions.

PATIENT/GUARDIAN SIGNATURE DATE

NOTICE OF PRIVACY

FREE STATE PRIMARY CARE, LLC, NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar process.

NOTICE OF PRIVACY

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical record; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at 100 Middletown Pkwy., Unit 202, PMB 10, Middletown, MD 21769.

FreeState PRIMARY CARE

NOTICE OF PRIVACY

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.
- **Right to an Accounting of Disclosures**. You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.
- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at 100 Middletown Pkwy., Unit 202, PMB 10, Middletown, MD 21769 or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

PATIENT/GUARDIAN SIGNATURE DATE

I hereby acknowledge that I have received and have been given and opportunity to read Free State Primary Care, LLC.'S Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact the Office Manager at 240-647-9049.

PATIENT SIGNATURE DATE

GUARDIAN SIGNATURE DATE

FreeState
PRIMARY CARE

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME ______ DOB ______ SSN ______

ADDRESS ______ PHONE ______

I authorize Free State Primary Care, LLC, to:

☐ Release my health information to the below facility/clinician ☐ Receive my health information from the below facility/clinician

NAME OF PROVIDER/FACILITY ______ EMAIL ______

ADDRESS ______ PHONE ______ FAX ______

TYPE OF DISCLOSURE

☐ Verbal/Written/Electronic ☐ Copies of Record ☐ Letter

PURPOSE OF DISCLOSURE

☐ Ongoing treatment ☐ Academic ☐ Support ☐ Other

DESCRIPTION OF INFORMATION TO BE DISCLOSED

☐ Assessment ☐ Diagnosis ☐ Psychiatric Evaluation ☐ Medication Management Info ☐ Discharge ☐ Other

By initialing below, you are authorizing the following information to be released:

____ **All counseling/mental health information** (Subject to MD's Confidentiality of Medical Records Act, codified at Health-General4-301 et seq.) Additionally, all information regarding alcohol and/or Drug Abuse (42. C>F.R. and 2.35) or HIV/AIDS results (Health and Safety Codes 120980(g)) will be released **unless restricted in Comments below.**

____ **All medication management services information medical information.** (This may include but is not limited to drug/alcohol and mental health information documented by the medical provider.)

____ I understand that this information may be transmitted via written word, facsimile, or over the phone.

____ I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.

____ I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.

____ **Comments regarding the release of information** (i.e. specific information you do not wish to be released):

______

REDISCLOSURE

I understand that there is the potential that the protected health information that is disclosed is pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

PATIENT NAME ______ DOB ______

SIGNATURE PATIENT/GUARDIAN ______

DATE ______

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PRIMARY CARE

TELEMEDICINE CONSENT

PATIENT NAME DOB

PROVIDER NAME DATE

Telemedicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different location than the healthcare provider. This may be for the purpose of diagnosis, treatment, follow-up and/or education. During your telemedicine consultation, details of your medical history and personal health information may be discussed with you or other health professionals through the use of interactive video, audio or other telecommunications technology. Additionally, a physical examination of you may take place, and video, audio, and/or photo recordings may be taken.

All efforts will be made to utilize electronic systems with network and software security protocols to protect the privacy and security of health information and to safeguard the data against corruption. However, in order to ensure greater access to care while limiting the spread of COVID-19, the mode of communication used during your telehealth consultation may not be secure and may be subject to privacy risks.

ANTICIPATED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her location while the healthcare provider provides care from a distant site
- Limiting the spread of COVID-19
- More efficient medical evaluation and management
- Ability to obtain consultation of a distant specialist
- Conservation of personal protective equipment such as gloves and masks to reduce shortages for healthcare providers

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, it may be determined that the information transmitted is of poor quality, requiring a face to face visit or rescheduled telemedicine visit. This may cause a delay in medical evaluation/treatment.
- Security protocols could fail or not be available, causing a breach of privacy of personal medical information.
- In rare cases, a lack of access to all of your medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

1. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed.
2. I understand that all efforts will be taken to protect the privacy and security of health information, and that no information obtained in the use of telemedicine which identifies me will be intentionally disclosed to researchers or other entities without my authorization.
3. I understand that during the COVID-19 pandemic, security measures may be lessened in accordance with U.S. Department of Health and Human Services (HHS) to ensure improved access to care.

TELEMEDICINE CONSENT

4. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time without affecting my right to future care or treatment.
5. I understand there may be technological challenges that prevent recording the telemedicine interaction during the COVID-19 pandemic, but that I have the right to inspect all information obtained and successfully recorded and may receive copies of this information for a reasonable fee.
6. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My healthcare provider has explained the alternative to my satisfaction.
7. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and/or (3) terminate the consultation at any time.
8. I understand that certain fees for service may be waived during the COVID-19 pandemic depending on my insurance carrier. While all efforts will be made to follow guidelines during this fluid situation, I may be responsible for any copayments or coinsurances that apply, and if my medical insurance coverage is not sufficient to satisfy any excess cost, I will be responsible for payment.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine during the COVID-19 pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

SIGNATURE

I have read and understand the information provided above regarding telemedicine during the COVID-19 pandemic. I have discussed and had an opportunity to ask my healthcare provider questions. All of these questions have been answered to my satisfaction.

☐ I hereby **AUTHORIZE** ______________________________ (name of physician/therapist) to use telemedicine in the course of my diagnosis and treatment.

☐ I hereby **REFUSE** ______________________________ (name of physician/therapist) to use telemedicine in the course of my diagnosis and treatment.

PATIENT/GUARDIAN SIGNATURE ______________________________ DATE ______________