SNOW INSIGHT MENTAL HEALTH PLLC

NEW PATIENT INFORMATION

PATIENT INFORMATION

Patient Name: _____

(First) (Middle) (Last)

Gender: _____ Preferred Pronouns if applicable: _____

Date of Birth: _____ Marital Status: _____

Driver License State and number: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

INSURED PARTY INFORMATION (If different than above)

Primary Policy Holder Name: _____

(First) (Middle) (Last)

Relationship to Patient: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Insured Party Date of Birth: _____

Last four od SSN: _____ Driver License State and number: _____

Insurance Company Name: _____

ID or Member #: _____ Member Service Phone: _____

Email Address: _____ Employer: _____

Occupation: _____

EMERGENCY CONTACT INFORMATION

In case of emergency call: _____

Relationship to patient: _____ Primary Phone: _____

Alternate Phone: _____ Email: _____

Signature: _____ Date: _____

SNOW INSIGHT MENTAL HEALTH PLLC

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form if you are seeing a therapist or counselor or would like to include other parties in your consent.

I, _____, authorize Snow Insight Mental Health PLLC providers and/or designated staff to disclose and provide information, including copies of specified protected health information regarding _____ (patient name)

to the following party (name of persons or entities to whom you would like information shared).

[ ] Therapist or Counselor _____

[ ] Other Party _____

Address:

_____

Phone Number: _____ Fax Number: _____

Protected health information I am authorizing for disclosure is: (Check all that apply

_____Psychiatric Evaluation
_____Progress notes
_____Medication Records
_____Treatment Plan or Summaries
_____Hospital Records Created by T.Snow
_____Mental Health Records
_____Substance Abuse Records
_____Lab Tests or Studies
_____Billing Records
_____Other (Specify)_____

Purpose of Disclosure:

_____ Request of authorized individual or patient
_____To assist in employment accommodations
_____In support of application for insurance
_____Insurance review of my claim for services
_____Continuation of care by another clinician
_____To assist in educational accommodations
_____Security investigation for employment
_____For review in legal matter

This authorization will be in force and effect until revoked in writing by me via Certified Mail to **Snow Insight Mental Health PLLC 5570 N Union Blvd STE203-A Colorado Springs, CO 80918**. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim. I understand that the information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my provider, and therefore, such disclosed information may no longer be protected by federal or state law. I hold Texas Behavioral Health systems providers and staff harmless for any adverse consequence derived directly or indirectly from the authorized release of protected health information.

_____ _____

Patient Name Date

_____

Printed Name (if different than above)

_____

Signature of Patient or Authorized individual

Notice to Recipient: This information is protected by Federal (42CFR, Part 2) and State laws regarding confidentiality. These statutes prohibit you from disclosing this information to anyone else. A general authorization is not sufficient regarding mental health and / or substance abuse treatment.

SNOW INSIGHT MENTAL HEALTH PLLC

COORDINATION OF CARE WITH PRIMARY CARE PROVIDER

Communication of your treatment plan with your Primary Care Provider (PCP) is important to your overall health care. Please sign the necessary authorization to release this information to your primary care physician.

Name of Primary Care Physician: _____
Address: _____
Phone Number: _____ Fax Number: _____

I, _____, authorize Snow Insight Mental Health PLLC to share with my primary care provider named above, any medical information regarding the following patient:
Patient Name: _____
This authorization is effective until revoked by me in writing.

_____ _____
Authorizing Signature Date

_____
Printed Name

****

[ ] Mailed or Faxed to PCP [ ] Logged into Database

To Primary Care Physician,
Your patient _____ DOB: ____ / ____ /____

was seen at our practice on _____.

Treating provider Twana Snow APRN, PMHNP-C

Treatment Plan/Medication (s):
_____
_____
_____
_____
_____

Purpose:
_____

Referral to Therapy: _____
Other: _____
Recommended Lab Monitoring: _____

****PLEASE SEND MOST RECENT VISIT NOTE AND LABWORK TO OUR OFFICE VIA FAX AT (719) 888-1751**

SNOW INSIGHT MENTAL HEALTH PLLC

CONSENT TO EVALUATE and//or TREAT MINOR
(Must be completed in regard to anyone under 18 years of age)

Note: Stepparent may not grant permission to evaluate and treat

In situations of divorce, a copy of your divorce decree section pertaining to custody and consent to medical care must be provided. If you are not the parent, but our legal guardian, you must provide court documents establishing guardianship.

I, _____ as the

( ) Parent

( ) Custodial Parent (In situations of divorce)

( ) Legal Guardian

Attest to have legal authority to grant consent and permission to licensed providers and associated clinicians (dba Snow Insight Mental Health PLLC) for psychiatric evaluation and treatment of:

_____ _____/_____/_____
Print name of minor Date of Birth

My name is: _____
Print Name

_____ _____
Signature of Parent or Guardian Date

_____ _____
Signature of Parent or Guardian Date

(In cases oof divorce where both parents have equal custody and share medical decision making, signatures of each parent are required)

CONSENT FOR TELEHEALTH

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up, and/or education. The electronic systems used for telehealth will incorporate network and software security protocols to protect patient privacy and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.
Expected Benefits: Telehealth offers improved access to medical care by enabling patients to remain in their home or secure location while a healthcare provider at an alternate location provides non-emergency medical evaluation, non-crisis care, treatment recommendations, medication management, and individual or family psychotherapy sessions.

Potential Risks: As with any behavioral health evaluation, there are potential risks associated with the use of telehealth. These risks include, but may not be limited to:
• In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the healthcare provider and consultant(s).
• Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
• In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
• In rare cases, a lack of access to complete 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 the laws that protect privacy and the confidentiality of medical information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. 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 provider has explained the alternatives to my satisfaction.
4. I understand that telehealth may involve electronic communication of my personal medical information to other medical providers who may be located in other areas.
5. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.

_____
Printed Name

_____ _____/_____/____
Signature of patient or legal guardian Date

Consent for Treatment/Financial Responsibility/Authorization to Release Medical Information

I, _____, am fully authorized to consent to treatment to be rendered to me, my child, _____
(Patient or responsible party—Please print)
or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees.
Such fees may include, but are not limited to, patient copays, co-insurance, deductibles, non-insured services (such as prescription renewals outside of your appointment time, pharmacy authorizations, telephone calls, document preparation, hospital admission coordination, etc.), or services deemed by my insurance company or its agents as medically unnecessary or not covered.

In the event that my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim.

Unpaid insurance claims and any associated charges are considered as supplemental charges.

Payment for services not utilizing insurance are due at the time of service.

A fee of $40.00 is charged for missed appointments, unless canceled 24 hours in advance.

The office does not file out of network claims but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.

I authorize Snow Insight Mental Health PLLC, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent to Snow Insight Mental Health PLLC and its employees that I have in force, and am entitled to, the benefits of any applicable health plan which I have presented. I hold Snow Insight Mental Health, PLLC and its employees harmless for any damages resultant from denial of payment, lack of certification, lack of payment for medically recommended treatment, or failure on the part of my insurance company or its agents to maintain confidentiality regarding my condition. I assign my insurance benefits to Snow Insight Mental Health, PLLC.

_____ _____
Patient (Recipient of Care)—Please Print Date

_____ _____
Signature Date

_____ _____
Responsible Party (if other than patient)—Please Print Date

Signature of Responsible Party _____

We require a credit or debit card for services not covered by insurance:
Unpaid balances for services rendered **including those listed above,** may be charged to the following Credit or Debit card [ ] VISA ( ) Mastercard [ ] DISCOVER

Card No. _____ Exp Date _____

Cardholder Name _____ (Please Print)

Cardholder Signature _____

Information Regarding Controlled Substance

The purpose of this information is to create an understanding regarding controlled substances.
Please initial each line to indicate understanding:

____ The goal of treatment is to reduce symptoms to a bearable level to improve the quality of my life. I understand that in many cases, symptoms may not be completely eliminated. Increasing doses may not always help, and in some cases may cause further complications.

_____ Use of illegal substances, alcohol and combinations of other mood-altering drugs, including prescription medications, can lead to dangerous side effects, including respiratory depression and death.

_____ Prolonged use of controlled medications may be associated with serious health risks that will be discussed by my provider, including dependence on or addiction to these medications.

_____ The risk of abruptly stopping a controlled medication may cause complications. If I need to stop this medication, I must do under the advice of my provider.

_____ Stimulant medications, such as Adderall, Ritalin, Vyvanse, etc… are known to influence the cardiovascular system. Your provider may periodically monitor your vital signs. If your provider has concerns about your blood pressure or pulse, clearance by a primary care provider or cardiology may be required.

_____ It is not advisable to combine stimulant medications with some medications, caffeine or energy drinks

_____Stimulants can cause other side effects such as heart palpitations, chest pain, blurred vision, syncope (fainting), activation of mania or psychosis, insomnia, increasing agitation/anxiety, seizure activity, weight loss, intolerable nausea or headache. Please notify your provider immediately if you experience any of these side effects or proceed to the nearest hospital emergency room for unrelieved chest pain.

_____ I am responsible for my medications. I will not share, sell, or trade my medication. I will not take anyone else's medication. Federal, state and local laws prohibit these actions.

____ I will not increase my medication dose unless approved by the prescribing provider.

_____ I will keep my medications in a secure place. My medicine may not be replaced if it is lost, stolen or used sooner than prescribed.

_____ My provider may order a blood, urine, or saliva sample to test for medications or drug use.

_____ I must use extreme caution regarding driving or operating heavy machinery when taking these medications as side effects can include drowsiness or a change in mental abilities, thereby making it unsafe to do so.

_____ I agree that drinking any amount of alcohol while I am receiving DEA controlled medication, especially benzodiazepines, could suppress my breathing, especially while sleeping, and result in death due to respiratory failure.

_____ I understand that if I become pregnant while taking these medications, my child may be born dependent on the medication and other health risks to my child may exist. It is not advisable to take controlled substances while pregnant. I will contact my provider immediately if I become pregnant.

_____ If I see another provider who gives me a controlled substance medicine (for example, a dentist, doctor from an Emergency Room or hospital, etc.), I must notify your office immediately.

_____ I understand that my medications may be changed or stopped at any point in my treatment at my provider's discretion.

_____ _____/_____/_____

Signature of patient or legal guardian Date

The "Off-Label" Use of Medication

There are times we prescribe medications which are not labeled specifically for usage in a particular condition. This is because the US Food and Drug administration FDA indications for any given drug is based on their review and acceptance of studies which have been submitted to them for uses in a specific diagnosis, rather than symptoms. Medications treat symptoms, not diagnosis. There are times when a medication is found to be useful for one symptom or disorder, but clinical experience reveals that it is also useful in other areas. When this occurs pharmaceutical companies occasionally conduct new medication trials and seek additional FDA approval. This pursuit of indication for use from the FDA is a business decision that many pharmaceutical companies decide not to make because of the extremely high cost of medication research and testing and the fact that medication has already received approval for prescribing. Most pharmaceutical companies decide to rely upon doctors learning of these additional uses through articles published in medical journals, professional educational forums, and collegial networking. The use of medications without FDA indications for a certain condition is referred to as quote "off label" use.

There are special circumstances in regard to children. Most all the medications that child psychiatrist, pediatric neurologist, and pediatrician use are used "off label". Considering the complications of testing medications on children (a child cannot sign a waiver stating that he/she understands the risks of being involved in medication research), there are very few medications that are "approved" by the FDA for children. An example of an "off label" use of medication with which you might be acquainted would be amoxicillin. Amoxicillin was widely used with adults and its success in treating infection led to its almost immediate embrace by pediatricians. Because it was already being used with children, the manufacturers never sought an approval indication and to this day amoxicillin is not approved by the FDA for use in children, although its use is nearly universal.

It is important for you to understand that the medication we recommend and prescribe have been shown to be helpful in the hands of many providers. We want you to be informed of the possible benefits and side effects of these medications and encourage you to read and ask questions that you have. We are committed to pursuing a plan of treatment which leads to the lowest dosage of medication and the smallest number of medications used, consistent with optimal level of wellness. Our goal for medication prescribed is to treat and reverse as many symptoms as possible while pursuing additional non medication strategies. Counseling and lifestyle changes can further add to the recovery from the presenting symptoms in the short-term. This will also enable the medication itself to work more effectively and may, in the long run, possibly negate the need for some or all of the medications originally prescribed.

Snow Insight Mental Health strives to be transparent with care recommended and to provide you all the information we can in order to help you make informed decisions concerning you and/or your child's care.

HEALTH INFORMATION PRACTICES
THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION UNDERSTAND YOUR HEALTH RECORD INFORMATION

This notice describes the practice of Snow Insight Mental Health PLLC and that of its licensed providers with respect to your protected health information created while you are a patient at Snow Insight Mental Health.Snow Insight Mental Health licensed providers and personnel authorized to have access to your medical chart are subject to this notice. In addition, we create a record of the care and services you receive at Snow Insight Mental Health. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at Snow Insight Mental Health. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of Snow Insight Mental Health, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care as provided by law. However, we are not required by law to agree to a requested restriction.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.
- Revoke your authorization disclose health information except to the extent that action has already be taken.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of this notice to the Practice Administrator at Snow Insight Mental Health.

Our Responsibilities:

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available at your request.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medication information. For each category, we will explain what we mean & give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment. For example: We may disclose medical information about you to your primary care physician or subsequent health care providers with copies of various reports to assist in treating you once you are discharged for Snow Insight Mental Health.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that may identify you, as well as your diagnosis.

Business Associates: There are some services provided in our organization through agreements with business associates. Examples including: copying services, accounting services, computer services, etc. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may leave appointment reminders on your answering machine or voicemail at home or work, or with a person answering the telephone.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law. For example: You may apply for Disability Insurance Benefits or Life Insurance. Your insurance carrier may request medical information to review your application.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and/or law enforcement purposes. We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

I acknowledge that I have reviewed and accept the Snow Insight Mental Health PLLC policy regarding Health Information Practices.

Notice Concerning Complaints

Complaints about licenses and registrants of the Colorado Division of Professions and Occupations, including physician assistants, advanced practice nurse, and acupuncturist, may be reported for investigation at the following address:

Colorado Division of Professions and Occupations
1560 Broadway Suite 1350
Denver, CO 80202
Phone: (303) 894-7800
Online at: dpo.colorado.gov

SNOW INSIGHT MENTAL HEALTH PLLC

Consent to treatment

I, _____ Date of Birth _____/_____/_____
As the person receiving treatment or guardian of minor receiving treatment, grant consent and permission to Snow Insight Mental Health PLLC for psychiatric evaluation and treatment.

Acknowledge of Receipt and Review of:

Office Policies

Authorization for Disclosure of Protected Health Information

Coordination of Care with Primary Care Provider

Consent for treatment/Financial responsibility/Authorization release medical info

Consent for Telehealth

Information Regarding Controlled Substances

The Off Label Use of Medication

Health Information Practices

Notice Concerning Complaints

By signing below, I am Agreeing that I have read, understand, and agree to the items contained in this document and all above listed forms.

_____
Patient Name (Print)

_____
Name of parent /legal guardian if applicable (Print)

_____ ____/_____/_____
Patient or Legal Guardian Signature Date