PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

Patient Name: ____________________________________ Social Security Number:_____-_____-______

Date of Birth: _____/_____/_____ Sex: M / F (Circle one) Married / Single / Divorced / Widow

Language: _________________ Race: _________________ Ethnicity: Hispanic / Non-Hispanic / Other

Address: ____
(Street) (City/State/Zip)

Primary Phone: (____) ________-______________ Secondary Phone: (____) ________-______________

Would you be interested in having communications sent to you via your email? (examples: appointment reminders, administrative updates and health bulletins)

Yes No

Email: ____

Employer Name: _____________________________________ Phone: (____) ________-______________

Employer Address: ____
(Street) (City/State/Zip)

Primary Care Physician: _____________________________________ _____________________________
(Name) (Phone)

How did you hear about our practice? ____

Pharmacy Name: ____
(Phone)

Person responsible for bill or parent/guardian ***(Complete only if different from patient)***

Guarantor Name: __________________________________ Social Security Number:_____-____-______

Relationship to Patient: (please check) ( ) self ( ) spouse ( ) parent Date of Birth: _____/_____/_____

Address: ____
(Street) (City/State/Zip)

Phone: (____) ________-______________ Email: ____

Employer Name: ____________________________________ Phone: (____) ________-______________

Employer Address: ____
(Street) (City/State/Zip)

Who to call for an emergency? ***(Not at same address as patient)***

Name: ______________________________________ Relationship to Patient: ____________________

Primary Phone: (____) ________-______________ Secondary Phone: (____) ________-______________

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Psychiatric Associates of Arkansas, PLLC. I further acknowledge that I am financially responsible for payment whether or not service is covered by my insurance policy.

____ ____________________________

Signature of Patient or Personal Representative Date

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ACKNOWLEDGEMENT FORM FOR NOTICE OF PRIVACY PRACTICES

I,_______________________________________, have received a copy of the Notice of Privacy Practices at Psychiatric Associates of Arkansas and consent to this notice.

____ ________________________
Signature of Patient Date

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FINANCIAL POLICY (Pg 2 of 2)

Also, it is understood and agreed that Psychiatric Associates of Arkansas reserves the right to assess a monthly finance charge, in accordance with Arkansas Law, to any unpaid balance due. Further, it is agreed that should Psychiatric Associates of Arkansas determine that it is necessary to employ a collection agency to recover any unpaid balance owed, I agree to pay any and all collection fees and costs expended to effect recovery, with such collection fees to be up to 50% of the unpaid balance due, including any and all attorney's fees assessed by any court.

APPOINTMENTS NOT CANCELED 24 HOURS IN ADVANCE ARE CHARGED A MISSED APPOINTMENT FEE OF $50 FOR MISSED INITIAL EVALUATION APPOINTMENTS AND $25 FOR MISSED DOCTOR FOLLOW-UP/MEDICATION MANAGEMENT APPOINTMENTS. PSYCHOTHERAPISTS ARE INDEPENDENT CONTRACTORS AND HAVE THEIR OWN MISSED APPOINTMENT POLICIES, WHICH THEY WILL DISCUSS WITH EACH PATIENT. ***Three missed appointments with no notification could result in dismissal from therapy!***

I UNDERSTAND I AM FULLY RESPONSIBLE FOR ANY OF THESE ABOVE MENTIONED FEES, AS THEY WILL NOT BE BILLED TO MY INSURANCE COMPANY!!

PLEASE READ THE ABOVE FINANCIAL POLICY CAREFULLY BEFORE SIGNING. WITH YOUR SIGNATURE YOU ARE ACKNOWLEDGING YOUR UNDERSTANDING OF OUR FINANCIAL POLICY.

____ ____________________________

Signature of Patient or Personal Representative Date

____

Printed Name of Patient

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FINANCIAL POLICY (Pg 1 of 2)

Thank you for choosing us as your health care provider. The following is a statement of Financial Policy which we require you to read and sign prior to any treatment.

PAYMENT OF DEDUCTIBLES, CO-PAYMENTS AND ANY NON-COVERED SERVICES ARE DUE AT THE TIME OF SERVICE. NON-INSURED PATIENTS ARE EXPECTED TO PAY IN FULL AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, AND DEBIT/CREDIT CARDS (MC, VISA, AMEX & DISC). THERE IS A $20 RETURNED CHECK FEE.

REGARDING INSURANCE

Your insurance coverage is a contract between you and your insurance company. If we are a contracted provider with your managed care company, we will handle your claims according to our agreement with your particular company. As a courtesy to you, we are happy to file your primary and secondary insurance. If you have more than two insurance companies, you will be responsible for filing the third insurance. **You are responsible for paying all deductibles, co-payments, and any non-covered services at the time of service.**

In the event we accept assignment of benefits, you are still ultimately responsible for all charges. **MEDICARE PATIENTS WILL HAVE A 20% COPAY (even though we take assignment)**. Arkansas law requires insurance to pay within 45 days. We will not become involved in disputes with your insurance company. If they have not paid within this time frame, we will expect payment from you. Our practice is committed to providing the best treatment for our patients and we charge what are usual and customary rates. Our fees are as follows: New Patient Initial Evaluation = $275; Individual Psychotherapy = $200; Medication Management = $100; Family Therapy = $195. **Please note: There will be a charge of $200 per hour (billed in 15 minute increments) for filling out any FMLA, disability, or other paperwork if they are not done during an appointment. Prescriptions issued outside of appointments may be billed a $10 fee, depending upon the circumstances.**

MINORS

The adult accompanying a minor is responsible for full payment. This is regardless of any divorce decrees (which is a contract between parents; not between you and your doctor). If an ex-spouse is responsible for a minor's bill, the adult accompanying the minor is responsible for paying the physician fees and then collect reimbursement from the ex-spouse. **PARENTS ARE RESPONSIBLE FOR SENDING CO-PAYMENTS WITH UNACCOMPANIED MINORS AT EACH VISIT. A parent or legal guardian must accompany a minor for their initial visit.**

DELINQUENT ACCOUNTS

I agree to be financially responsible for any unpaid balance due to Psychiatric Associates of Arkansas for services rendered. I understand that even though I have insurance, some diagnosis may not be covered under that insurance plan. If this occurs, I agree to pay the full fee for services.

I grant permission to Psychiatric Associates of Arkansas, its agents or assigns, to discuss my account with and release any information to any third party payer via the U.S. Postal Service, fax, or any electronic media in order to assist in the payment of any balance due, or otherwise verify personal information provided.

(continued on Pg 2)

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FINANCIAL POLICY (Pg 2 of 2)

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(Patient's Copy)

PSYCHIATRIC ASSOCIATES OF ARKANSAS, PLLC

9601 BAPTIST HEALTH DRIVE, SUITE 1050
LITTLE ROCK, AR 72205

Dear Patient:

Your fee is based on the time we spend with you during your visit, the complexity of your condition, and any treatment provided. But proper attention to your care also requires that we spend additional time beyond that which we spend with you in the office. Such time may be used to:

- Create and maintain your permanent medical record.
- Review, interpret, & document all lab test results & communicate those results to you.
- Consult via phone about your case with referring or consulting physicians and other health care providers.
- Provide written reports to your insurance company, your disability company, your employer, Social Security Administration, etc., per your request.
- Conduct medical/psychiatric research relevant to your case.
- Communicate with pharmacies about your prescriptions.
- Complete insurance applications and claim forms. Call your insurance company for benefits, payment information, etc. Obtain pre-certification for all treatment.
- Call your insurance company claims department when payment is not received within state guidelines (45 days).
- Conduct utilization review negotiations with hospitals and insurance companies.
- Dictate, review and manage hospital records.
- Draft letters of medical necessity to obtain medical services or prescriptions you need.
- Arrange for hospital admissions and follow-up consultations with nurses, attending physicians, and house staff.
- Draft reports and forms, including home health care orders and nursing facility orders.
- Respond to your telephone calls and web portal emails.

Our out-patient fees are as follows:

- Initial Evaluation: $275 – includes time with a physician, treatment recommendations for follow-up care including therapy with a social worker or counselor, medication recommendations, and prescriptions as needed.
- Individual Psychotherapy: $200 per 45-60 minute session with a PhD, LPC, LPE or LCSW.
- Medication Management: $100 per 10-15 minute session with an MD Psychiatrist.
- Family Therapy: $195 per 45-60 minute session.

All of these activities add to our cost of doing business. Still, we are committed to providing you the best possible care. We hope this explanation of our fees has been helpful. With you, our patient, we look forward to a lasting and healthy relationship.

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YOU DO HAVE THE RIGHT:

- To treatment regardless of race, color, sex, religion, national origin, age, handicap or professional status.

- To be treated with consideration, respect, and individual dignity.

- To know the identity and professional status of individuals providing services to you.

- To an individual treatment plan which shall include the nature of care, procedures and treatment received and to have the plan periodically reviewed and updated in keeping with your health status.

- To participate in planning your treatment and aftercare.

- To obtain information concerning your diagnosis, treatment, and known outcome of your treatment. You have a right to an explanation of your condition, medications, procedures for treatment, alternatives for care or treatment, problems related to recuperation and probability of success.

- To be informed of the risks and side effects of any proposed treatment and the right to be informed of alternative treatments.

- To refuse treatment to the extent permitted by law. Medication and treatment are given only for your welfare. When refusal of treatment by you or your legal representative prevents the provision of appropriate care in accordance with professional standards, the relationship established between you and PAA may be terminated upon reasonable notice.

- To request and receive an itemized and detailed explanation of your total bill for services. You have a right to timely notice prior to termination of your eligibility for reimbursement by any third-party payer for the cost of your care.

- To confidentiality. All communication and records pertaining to your care, including the source of payment for treatment, shall be treated as confidential and will not be given to anyone without proper authorization, except in accordance with state and local laws which require reporting of all cases in which there is abuse or neglect of minors or where there exists a danger to self or others. Legal subpoena by the court cannot be refused and records must be provided. PAA will hand deliver sealed records to the judge in this instance.

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NOTICE OF PRIVACY PRACTICES (Pg 1 of 4)

Revised 09/20/17

This notice describes how medical information about you may be used or disclosed, and how you may gain access to this information.

I, ______________________________________, consent to the use or disclosure of my protected health information (PHI) by Psychiatric Associates of AR, PLLC, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operation of Psychiatric Associates of AR. I understand that diagnosis or treatment of me by Richard Owings MD, PhD, Duong Nguyen MD, Philip Mizell MD, CPE, Marcela Johnston PhD, Nancy Golden LPEI, Garry Teeter MS, LPC, NCC, CBIST, Lindsay Oliver LPC, or Nancy Lasiter Kozlowski LPC, may be conditioned upon my consent as evidenced by my signature on this document. I request payment of authorized Medicare or other insurance benefits due to me, be paid directly to Psychiatric Associates of AR (Fed Tax ID #71-0764753) for services rendered by any of the above named providers.

My “protected health information” (PHI) means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or healthcare clearinghouse. This PHI relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

How we may use & disclose your PHI:

For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company, or another third party.

For Health Care Operations. We may use & disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for you, for audits or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits & Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care or to tell you about health related benefits & services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a special representative, such as a legal guardian, we will treat that person as if that person is you and with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ & Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation or transplantation.

Military & Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the FDA for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or stability; (3) report child abuse or neglect; (4) report births & deaths; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, & similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, descriptions , or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose PHI to those officials so they may protect the President.

Coroners, Medical Examiners, & Funeral Directors. We may release PHI to a coroner, medical examiner, or funeral director so that they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with healthcare; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Psychotherapy notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health

professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

Uses and Disclosures that Require Us to Give You an Opportunity to Object and Opt Out

Individuals Involved in Your Care of Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicably can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends or your relocation or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required to Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization, If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health, and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. You will be charged a fee for the cost of copying, mailing or other supplies associated with your request. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. You will be charged a fee for the cost of copying, mailing or other supplies associated with your request.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by email of any breach of your unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to our Privacy Officer at the address provided at the beginning of this notice and it must tell us the reason for your request.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosure," which is a list of the disclosures we made of your PHI. We are NOT required to list certain disclosures, including, (1) disclosures made for treatment, payment and health care operation purposes, (2) disclosures made with your authorization, (3) disclosures made to create a limited data set, and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your requests must state a time period which may not be longer than 6 years before your request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment for your care.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy.

How to Exercise Your Rights

To exercise your rights in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. To get a paper copy of this Notice, contact our Privacy Officer by calling our office number.

Changes to this Notice

The effective date of this Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address and phone number listed at the beginning of this notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation.

I understand I have the right to review Psychiatric Associates of AR Notice of Privacy Practices prior to signing this document. Psychiatric Associates of AR Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the type of uses and disclosure of my PHI that will occur in my treatment, payment of my bills or in the performance of health care operations of Psychiatric Associates of AR.

The Notice of Privacy Practices for Psychiatric Associates of AR is also provided at 9601 Baptist Health Drive, Suite 1050, Little Rock, AR, 72205. This Notice of Privacy Practices describes my rights and Psychiatric Associates of AR's duties with respect to my protected health information.

Psychiatric Associates of AR reserves the right to change the privacy practices that are described in the notice. I may obtain a revised Notice of Privacy Practices by calling the office at (501) 228-7400 and requesting a revised copy to be sent in the mail or asking for one at the time of my next appointment. If you have questions about this notice or need more information, please contact our privacy officer.

(Patient's Copy)