Reclaim Mental Health, LLC
Akiva Daum, MD FAPA
Board Certified General and Addiction Psychiatry

3275 W Hillsboro Blvd Suite 300D
Deerfield Beach, FL 33442
954-451-2592

Intake Form

Patient's Name:_________________________________ Birth Date: _______________________

Responsible Party: ______________________________ Is patient a minor? Yes No

Insured's Name (if other than patient): ____

SSN of insured: _________________________________ Insureds Birth Date: ______________________

Street Address: ____

City, State, Zip: ____

Phone (circle preferred): Home______________Cell__________________Work___________________

Please Note: You will be texted a reminder of your appointment unless you opt out. Opting out of confirmations will not eliminate responsibilities with regards to keeping appts

Email address: ____

Marital Status: Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed [ ]

Currently Employed Yes No Patient's Occupation: ____________________________

Patient's Employer: ____

Employer Address: ____

City, State, Zip: ____

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INSURANCE BILLING POLICY AND FINANCIAL RESPONSIBILITY

Our fees generally fall within the reimbursement guidelines for medical and/or psychotherapy in this area. However, there is no guarantee that your insurance company will cover the entire fee. You may have an insurance policy that has payment limitations, makes payments based on a set fee schedule or makes payments on approved visits through managed care. <u>The insurance you have is a contract between you and your insurance carrier; you should be aware of your policy and its limitations.</u>

You are responsible for payment of all deductible co-payment and coinsurance amounts insurance company does not pay. <u>You will be responsible for payment in full.</u> Please be aware that we file your insurance claim or provide a billing receipt as a courtesy to you. You are responsible for keeping track of all of your sessions including those with other providers, and how many visits your insurance coverage allows per calendar year combined. Should your benefits be exhausted for the year you will be responsible for any unpaid services and for future visits until benefits resume.

In circumstances where benefits are exhausted through your insurance company, or if there is no longer insurance coverage in effect it is your responsibility to notify your provider in order to establish the total fee that is your responsibility for ongoing visits.

It is your responsibility to keep your appointments as scheduled. Failure to keep an appointment and/or failure to notify the office of an appointment cancellation at least 24 hours prior to the appointment will incur a minimum of the cost of the missed visit. Please discuss any concerns about a cancellation fee with our office staff.

Checks returned from you bank for any reason will incur a $45.00 fee on your account. Any fees associated with declined credit cards will incur a fee commensurate with the fee charged for a declined transaction, (typically $1-5 though this may vary). In the event that a fee is incurred, it must be paid in addition to the original amount by cash or another guaranteed form of payment.

In the event that outstanding balances on my account remain unpaid and l fail to arrange a payment plan, I understand that collection procedures will begin. I will be responsible for any interest accrued and the costs of collection, including attorney's fees.

_____________________________ _____________________________

Print patient's name Date

____

Patient's signature (parent if minor)

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CONSENT TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

As a condition of providing treatment to you, a healthcare provider from Reclaim Mental Health, LLC may request your consent to use and disclose protected health information about you to carry out treatment, payment, and healthcare operations.

You may revoke this consent at any time by notifying Reclaim Mental Health, LLC in writing, except to the extent that the provider has taken action and reliance on your consent.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that Reclaim Mental Health, LLC may use of your protected health information. You have the right to review the Privacy Notice prior to signing this consent.

Reclaim Mental Health, LLC have reserved the right to change its privacy practices described in this Privacy Notice. In accordance with law, the terms of the Privacy Notice may change. At any time, you may obtain a copy of the current Privacy Notice and any revised notice.

You have the right to request that Reclaim Mental Health, LLC restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment, or healthcare operations. Reclaim Mental Health, LLC is not required however, to agree to such requested restrictions. If, however, Reclaim Mental Health, LLC agree to the requested restriction, they will honor the request and it will be binding.

I hereby consent to the use and disclosure by Reclaim Mental Health, LLC, its workforce, and its business associates of my protected health information for purposes of treatment, payment, and healthcare operations.

Signature____

Signature of Personal Representative of Patient____

Representatives Authority to Act on Behalf of Patient____

Date: __________________________

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MENTAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA). It describes how we may use or disclose your protected health information, with whom that information may be shared, and the safeguards we have in place to protect it. This notice also describes your rights to access and amend your protected health information. You have the right to approve or refuse the release of specific information outside of our office except when the release is required by law or regulation.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

You will be asked to provide a signed acknowledgement of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care services will in no way be conditioned upon your signed acknowledgement. If you decline to provide a signed acknowledgement, we will continue to provide your treatment and will use and disclosed your protected health information for treatment, payment, and healthcare operations when necessary.

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices.

Signature____

Signature of Personal Representative of Patient____

Description of Representative's Authority to Act on behalf of patient___________________________

Date: ____

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CONSENT FORM FOR ePRESCRIBE PROGRAM

ePrescribe Program

ePrescribing is a way for doctors to send electronically an accurate, error free, and understandable prescription from the doctor's office to the pharmacy. It is now being mandated by many states, including the State of Florida, the ePrescribe Program includes:

- Medication history transactions – Provides the health care provider with information about your current and past prescriptions. This allows health care providers to be better informed about potential medication issues and to use that information to improve safety and quality. Medication history data can indicate: compliance with prescribed regimens; therapeutic interventions; drug-drug and drug-allergy interactions; adverse drug reactions; and duplicate therapy.

The medication history information would include medications prescribed by your psychiatrist as well as other health care providers involved in your care and may include sensitive information including, but not limited to, medications related to mental health conditions (including addiction/substance use) venereal diseases, and HIV/AIDS. *As part of this Consent Form, you specifically consent to the release of this and other sensitive health information.*

Consent

By signing this consent form, you are agreeing that Reclaim Mental Health, LLC may request and use your prescription medication history from other healthcare providers and/or third-party pharmacy benefit payors for treatment purposes.

You may decide not to sign this form. Your choice will not affect your ability to get medical care, payment for your medical care, or your medical care benefits. Your choice to give or to deny consent may not be the basis for denial of health services. You also have a right to receive a copy of this form after you have signed it.

This consent form will remain in effect until the day you revoke your consent. You may revoke this consent at any time in writing but if you do, it will not have an effect on any actions taken prior to receiving the revocation.

Understanding all of the above, I hereby provide informed consent to Reclaim Mental Health, LLC to enroll me in the ePrescribe Program. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

Print Patient Name____ Patient DOB_________________

Signature of Patient or Guardian_______________________________ Date_______________________

Relationship to Patient____

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INFORMED CONSENT CHECKLISTFOR TELEHEALTHSERVICES

We have discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions
- Confidentiality still applies for telehealth services and nobody will record the session without the permission from the others person(s)
- We agree to use the video-conferencing platform selected for our virtual sessions, and the provider will explain how to use it
- A computer with a webcam or a smartphone will be used during the session
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi
- It is important to be on time and in the virtual waiting. If you need to cancel or change your tele-appointment, you agree to notify Reclaim Mental Health, LLC in advance by phone or email.
- We agree to a back-up plan (e.g. phone number where you can be reached) to restart the session or to reschedule it in the event of technical problems
- We agree to a safety plan that includes at least one emergency contact and the closest ER to your location in the event of a crisis situation
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telehealth sessions
- If appropriate, you should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment
- As your provider, I may determine that due to certain circumstances, telehealth is no longer appropriate and that we should resume our sessions in-person

I understand that certain services are not available through telehealth services and that in person visits may be required.

Patient Name____ Date_____________________________

Signature of Patient/Patient's Legal Representative____

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CLIENT STATEMENT OF UNDERSTANDING

I understand that confidentiality of records and information about me will be held in accordance with state laws regarding confidentiality. I understand that by law that confidential information may be provided under the following circumstances:

1. If I give written permission requesting release of information
2. If a court orders the release of my records
3. If I raise my mental status or competency in a legal proceeding.
4. If there is reason to believe that I may be a danger to myself or to others.
5. If there is evidence or reason to suspect child abuse or neglect of a child or an elderly, incompetent, or disabled person.

I have read and understand the above.

Signature________________________________ Date______________________________

SIGNATURE ON FILE

I authorize the release of any payment and medical information necessary to process my or my family member's claim and related claims. Please accept a photocopy of this authorization as if it were an original authorization. My signature below acts as a signature on file.

Signature________________________________ Date______________________________

ASSIGNMENT OF BENEFITS

I hereby authorize direct payment of insurance benefits to Reclaim Mental Health, LLC for professional services rendered. I understand that I am financially responsible for all charges not covered by this assignment.

Signature________________________________ Date______________________________

LATE CANCELLATIONS/ NO SHOWS

I understand that without 24hour notice of cancellation to my appointment I may be charged a fee the equivalent of the cost of the session as well as any additional fees associated with that session (late visit premiums, etc.)

Signature________________________________ Date______________________________

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"Good Faith Estimate"

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost.

Under the law, health care providers need to give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprisesorcall.

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MISSED OR CANCELLEDAPPOINTMENT POLICY

Please provide 24 hours' notice, should you no longer be available for your appointment - excluding weekends and holidays.

You will not be charged if you cancel your appointment with 24 hours' notice, excluding weekends and holidays.

(For example: If you have a Monday morning appointment you would have to cancel by Friday morning to avoid any fees).

You will be charged the full fee for appointments missed or cancelled without a 24-hour notice, excluding weekends and holidays. The fee will include any additional premiums such as evening appointment premiums.

Repeat no-shows or late cancellations may lead to dismissal from the practice.

This policy helps us ensure that clients on the waiting list can make an appointment and, also allows us to continue offering the highest levels of care.

ACKNOWLEDGEMENT OF RECEIPT

I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE CANCELLED OR MISSED APPOINTMENTS POLICY

DATE____

SIGNATURE____

NAME____

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CREDIT CARD ON FILE POLICY

Reclaim Mental Health, LLC will require keeping your credit or debit card on file as a convenient method of payment for the services you or your family member has received including insurance co-payments.

Your credit card information will be kept confidential and secure in our encrypted system to provide you with a high level of security.

I authorize Reclaim Mental Health, LLC to charge my credit card, indicated below, for balances due for services rendered to myself or members of my family, including any fees incurred such as late fees, premiums, urine drug screens, or returned payment fees. If an instance occurs where you prefer to pay by cash or check, you may do so and your credit card will not be charged.

This authorization will remain in effect until I cancel this authorization. To cancel, I must give 30-day notification to Reclaim Mental Health, LLC in writing and the account must be in good standing.

Credit Card Information

Please write legibly. Please double check the numbers you've written to ensure correct information is given.

Credit Card Number____

CVC______________________________ Expiration Date____________________________

Name of Card Holder____

Address of Card Holder____

Signature____

Email address____

Patient Name (Print) ____

Date____