NEW PATIENT INFORMATION

DISCLAIMER: A doctor-patient, provider-patient, or therapist-client relationship is not established until completion of your first appointment. You will not be considered a patient (or client) of Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC, or its associates until then. Completing these forms does not guarantee an appointment. If we determine our services are not adequate to meet the level of care required, we will notify you within a reasonable time frame.

FIRST NAME _____ LAST NAME:_____

ADDRESS: _____

CITY:_____STATE: _____ ZIP:_____

EMAIL ADDRESS: _____

PREFERRED PHONE NUMBER: (_____)_____

SECONDARY PHONE NUMBER:(_____)_____

BIRTHDATE: ____/____/_____ SEX _____ MARITAL STATUS_____ AGE:_____

SOC SEC #_____-_____-_____

EMPLOYER_____

EMERGENCY CONTACT NAME: _____ NUMBER(_____)_____

RELATIONSHIP TO PATIENT:_____

HOW DID YOU HEAR ABOUT US?
_____
_____
_____

PRIMARY CARE PHYSICIAN

NAME:_____ PHONE (_____)_____ FAX:
(_____)_____

ADDRESS: _____ CITY:_____ STATE: _____
ZIP:_____

THERAPIST OR OTHER MENTAL HEALTH PROVIDER
NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____
ZIP:_____

PASTOR OR SPIRITUAL LEADER
NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____
ZIP:_____

PHARMACY INFORMATION
NAME:_____ PHONE (_____)_____

ADDRESS: _____ CITY:_____ STATE: _____
ZIP:_____

REASON(S) FOR SEEKINGTREATMENT: _____

CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)
MEDICATION NAME / DOSAGE / SCHEDULE (e.g AM, PM) / REASON FOR TAKING

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

DRUG/FOODALLERGIES:_____

MEDICAL CONDITIONS (CURRENT/PAST MEDICAL PROBLEMS, SURGERIES, HEAD INJURIES, ETC):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

PAST TREATMENT HISTORY (circle 'Yes' or 'No' and elaborate on any "Yes" responses):

HAVE YOU EVER SEEN A PSYCHIATRIST BEFORE? Yes No _____

HAVE YOU EVER HAD COUNSELING/THERAPY BEFORE? Yes No _____

HAVE YOU RECEIVED A PSYCHIATRIC DIAGNOSIS? Yes No _____

HAVE YOU EVER BEEN PSYCHIATRICALLY HOSPITALIZED? Yes No _____

HAVE YOU TAKEN PSYCHIATRIC MEDICATIONS? Yes No _____

HAVE YOU BEEN DIAGNOSED WITH DEVELOPMENTAL DELAYS? Yes No _____

HAVE YOU BEEN TREATED FOR ALCOHOLISM/SUBSTANCE DEPENDENCE? Yes No _____

HAVE YOU EVER ATTEMPTED SUICIDE OR TRIED TO HARM YOURSELF? Yes No _____
_____

OTHER SIGNIFICANT PSYCHIATRIC HISTORY: _____
_____

IS THERE ANY FAMILY HISTORY OF: (PLEASE NOTE RELATIONSHIP TO PATIENT)

DEPRESSION: Yes No _____

BIPOLAR DISORDER OR MANIC-DEPRESSION: Yes No _____

ANXIETY DISORDER: Yes No _____

ADHD: Yes No _____

AUTISM: Yes No _____

OTHER MENTAL ILLNESS: Yes No _____

ATTEMPTED/COMPLETED SUICIDE: Yes No _____

ALCHOLISM: Yes No _____

SUBSTANCE ABUSE: Yes No _____

OTHER MEDICAL PROBLEMS (HIGH BLOOD PRESSURE, CANCER, SEIZURES, NEUROLOGICAL CONDITIONS, HEART PROBLEMS, DIABETES, ETC)_____
_____

OTHER SIGNIFICANT FAMILY HISTORY: _____

POLICIES AND PROCEDURES
FOR NEXT STEP 2MH, KENTUCKY PSYCHIATRIC AND MENTAL HEALTH SERVICES (KPMHS), PLLC, AND ASSOCIATES

CONSENT FOR TREATMENT: I consent to evaluation and treatment by the providers and staff of Next Step 2MH, Kentucky Psychiatric and Mental Health Services (KPMHS), PLLC [1] and/or Associates. I understand this consent does not constitute a guarantee about the results of my treatment. I understand I can terminate this consent for treatment at any time. I also understand that my doctor, prescribing provider, therapist, or counselor may terminate consent for treatment at any time, and will discuss the reasons with me if this should occur. Potential reasons include misuse of prescribed medications or mental health services, failure to reimburse for services rendered, failure to keep appointments or repeated cancellations of appointments, etc.

AGREEMENT TO PAY: I agree to pay all charges for professional services. Payment is due at the time of service. Any accumulated charges must be paid prior to any subsequent visit.

FEES: Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC and its associates operate on a fee-for-service basis. We do not accept Medicare, Medicaid, or any other form of private or commercial insurance. Fees are subject to change to keep pace with inflation, business overhead, and other factors to the discretion of Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC and its associates.

In some circumstances we may provide you with documentation that could be used by you to file an insurance claim with your insurance carrier. However, Next Step 2MH, KPMHS and its associates cannot guarantee that your insurance company will reimburse for services rendered. Should you choose to pursue this route, you take full responsibility for filing the claim and following through with any actions required by the insurance company. Next Step 2MH, KPMHS and its associates reserve the right to charge additional administrative fees related to insurance claims when appropriate.

In addition to charges for the initial evaluation and follow-up appointments, Next Step 2MH, KPMHS and its associates will charge fees for additional services, including but not limited to the following: preparation of reports, consultation with other medical or psychological specialists, participation in depositions and court appearances, conferences with attorneys, prior authorization for insurance approval of medications, and other services that require a professional time and expertise. If prescribing a DEA regulated/controlled medication, your provider may require periodic urine drug screening. Next Step 2MH, KPMHS and its associates reserve the right to charge for phone calls under certain circumstances. I understand that I am personally responsible for these charges and agree to pay the fees in full no later than my next follow-up appointment(s). In the event of nonpayment I agree to pay such costs and fees as may be required to effect collection of the indebtedness.

CANCELLATIONS: I understand that when I schedule an appointment, this time is specifically allocated for me. Cancelled appointments must be made no later than the previous business day and at least 24 hours before the appointment (for example, I must notify my psychiatrist by Friday at 2 PM if my appointment is Monday at 2 PM). **If a cancellation is not made within that time or is missed without notification, I understand that I will be charged the full price for the appointment.**

MEDICATIONS: If medications are prescribed to me by my doctor or other KMPHS provider, I understand that I am responsible for complying with my medications. I will make sure that I have an adequate supply of medication(s) until my next appointment. I understand that medications will not be prescribed or refilled after hours, on weekends, or holidays. I understand that if I need a medication refilled before my next visit, I will **CALL Next Step 2MH, KPMHS (NOT the pharmacy) to request a refill**, and that I can expect it to be addressed within 5 business days. I understand that in the event of a missed, rescheduled, or cancelled appointment, my medications may not be refilled. Prescriptions for controlled substance refills will likely require an appointment with the doctor or prescribing provider.

AFTER HOURS: I understand that calling the office after regular business hours, weekends, or holidays will provide me with information as to how to contact the on-call provider. I understand that this may not be my own

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[1] *DISCLAIMER: A doctor-patient, provider-patient, or therapist-client relationship is not established until completion of your first appointment. You will not be considered a patient (or client) of Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC or its associates until then. Completing these forms does not guarantee an appointment. If we determine our services are not adequate to meet the level of care required, we will notify you within a reasonable time frame.*

doctor or prescribing provider. I understand that this service should only be utilized for urgent matters that cannot wait until the next business day.

EMERGENCIES: I agree to contact my doctor, prescribing provider, therapist, or counselor immediately regarding any urgent medical/psychiatric/psychological issues, including significant side-effects of medication and any significant changes in mood/ behavior. If I am unable to reach my doctor/prescriber/therapist/counselor I will call 911 or proceed directly to the nearest emergency room. Under any circumstances where my situation becomes physically unsafe – whether due to a medical emergency such as unexplained or excessive physical symptoms, dangerous psychiatric symptoms (including agitation, thoughts of suicide or violence), or any other urgent problem(s) I will immediately call 911 directly or proceed to the nearest emergency room, so that those trained personnel can provide immediate professional emergency services.

CONTACT: If I need to contact any of the staff of Next Step 2MH, KPMHS or associates for non-urgent matters, I can call during regular business hours. If staff is not available, I am responsible for leaving a message that includes my name and date of birth, explains the nature of the call, and includes information on how to be contacted. I will allow my doctor, provider, therapist, counselor or designated representative to leave messages on my answering machine/voicemail unless I specifically request otherwise, with the understanding that every effort will be made to maintain confidentiality.

RETURNED CHECKS: If I choose to make payment by check and my check be returned for insufficient funds, I expressly authorize my account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. I also authorize Next Step 2MH, KPMHS and Associates to charge additional administrative fees for handling bad check(s). The use of a check constitutes my acknowledgement and acceptance of this policy

PROVIDER ABSENCE: I understand that if I have an emergency while my doctor, prescribing provider, therapist, or counselor is on leave, that Next Step 2MH, KPMHS and/or its associates will make arrangements for another professional (who may not be employed by Next Step 2MH/KPMHS) to provide covering services. The covering professional will have access to my confidential medical information during this time.

EMAIL: Next Step 2MH, KPMHS and its associates may occasionally utilize email messaging systems to notify me of my appointment time and/or deliver certain forms for me to fill out. I understand that email is not a confidential means of communication. I understand that my provider will likely NOT reply to my email(s) and I understand that email is not the appropriate way to handle confidential information and I understand that Next Step 2MH, KPMHS and its associates will NOT utilize email to answer questions related to my medical/psychological care. I agree to NOT contact my doctor, prescribing provider, therapist, or counselor by email with questions related to my mental health care.

STUDENT OBSERVERS AND PSYCHIATRISTS IN TRAINING: Next Step 2MH, KPMHS and/or its associates may hold faculty and/or teaching appointments with various academic institutions. Students and residents from these programs are occasionally provided an opportunity to shadow/observe our doctors, therapists, and/or counselors in private office and 'sit-in' on sessions with patients. Student observers have received training regarding the importance of keeping personal information private and are held to high standards regarding confidentiality. However, I understand that *I have the right to request that students not be allowed in the room during my session*. If that is my preference, I will tell my provider and I understand that my preference will be respected. I understand that my care takes precedence over the teaching of students.

PHOTOCOPIES: I agree that photocopies and electronic copies of this form are as valid as the original.

The invalidity of any provision of this agreement will not affect the validity of any other provision.

I certify that I have read the Policies and Procedures document, understand the contents of this document, and consent to the policies described above.

_____ _____

Signature (Patient/Client or Patient's/Client's Representative) Date

_____

Printed Name

_____ _____

Printed Name of Representative given authority to act for patient/client Date

NOTICE OF PRIVACY PRACTICES
FOR NEXT STEP 2MH, KENTUCKY PSYCHIATRIC AND MENTAL HEALTH SERVICES, PLLC AND ITS ASSOCIATES

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

The confidentiality of your personal health information is very important to this medical/psychological practice. Your medical/psychological record, generally containing information your symptoms, test results, diagnoses, and treatment, serves as a basis for planning your future care and treatment. We use this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this office, whether made by your personal provider or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of your privacy rights and of legal duties and privacy practices with respect to your protected health information. We are required to abide by the terms of this notice but reserve the right to change the terms of this notice. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. You may request a copy of our Privacy Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This could involve our staff and/or may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death, or necessary to prevent or lessen a serious and imminent threat to the health or safety of any person or the public. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up certain forms of health information and/ or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information could include, but are not limited to, medical records staff, outside health or management reviewers (only with your consent) and individuals performing similar activities. **Required by Law**: We may use or disclose your health information when we are required to do so by law (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/ or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to provide a request for this in writing.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you believe that we may have violated your privacy rights, or you disagree with a decision we made about access to your protected health information or in response to a request you made, you may complain by contacting our practice at our current address. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your compliant with the U.S. Department of Health and Human Services upon request.

We support your right to protect the privacy of your protected health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

I certify that I have read the privacy of practice notice, understand the contents of this document, and consent to the policies describe herein. I understand that the Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC and its associates have the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

_____ _____

Signature (Patient/Client or Representative) Date

_____

Printed Name

_____ _____

Printed Name of Patient's Representative given authority to act for patient/client Date

Acknowledgment of Medicare Status

Some of the providers with Next Step 2MH, KPMHS (or associates) may participate with Medicare through other clinics and/or hospitals. However, Next Step 2MH and KPMHS are not equipped to bill Medicare, and hence unable to serve Medicare beneficiaries.* By signing this statement I testify that I am NOT currently a Medicare beneficiary and will notify Next Step 2MH/KPMHS staff and/or my doctor immediately if I become a Medicare beneficiary at any time in the future.

** Exception: if you have a Medicare ADVANTAGE PLAN through a private insurer, we may still be able to see you in the office as an out-of-network provider, but cannot bill your insurance for you. Ask our staff for details. However, if you do NOT have a Medicare Advantage Plan and your Medicare is administered strictly by CMS we will not be able to provide services to you.*

_____ _____

Signature (Patient/Client or Representative) Date

_____

Printed Name

_____ _____

Printed Name of Representative given authority to act for patient/client Date

Acknowledgment of MEDICAID Status

Some of the providers with Next Step 2MH/KPMHS (or associates) may participate with Kentucky Medicaid or Medicaid Managed Care Companies (e.g. WellCare, Passport, CoventryCares, etc.) through other clinics and/or hospitals. However, Next Step 2MH/KPMHS is not equipped to bill Medicaid or any of the Medicaid MCO's, and hence unable to serve Medicaid beneficiaries.

By signing this statement I testify that I am NOT currently a Kentucky Medicaid beneficiary and will notify staff and/or my doctor immediately if I become a Medicaid beneficiary at any time in the future.

_____ _____

Signature (Patient/Client or Patient's/Client's Representative) Date

_____

Printed Name

_____ _____

Printed Name of Representative given authority to act for patient/client Date

Patient Information and Consent Form for Videoconferencing

Introduction

Telepsychiatry/Telepsychology is the delivery of psychiatric or psychological services using interactive audio and visual electronic systems where the doctor/therapist/or counselor and the patient/client are not in the same physical location.

The interactive electronic systems used in telepsychiatry/telepsychology incorporate network and software security protocols to protect the confidentiality of patient/client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption.

Potential benefits

- Increased accessibility to medical and psychological care
- Patient/client convenience

Potential Risks

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

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate decision making by our doctors, therapists, or counselors.
- Our providers may not be able to provide treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential information.
- A lack of access to all the information that might be available in a face-to-face visit but not in a videoconferencing session may result in errors in judgment on the part of the doctor, therapist, or counselor.

Alternatives to the use of videoconferencing

- Traditional face-to-face sessions in an office-based setting.

My Rights

- I understand that the laws that protect the privacy and confidentiality of medical and psychological information also apply to videoconferencing.
- I understand that the videoconferencing technology used by my doctor, therapist, or counselor is encrypted to prevent the unauthorized access to my private information.
- I have the right to withhold or withdraw my consent to the use of videoconferencing during the course of my care at any time.
- I understand that Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC (KPMHS) and its associates have the right to withhold or withdraw its consent for the use of videoconferencing during the course of my care at any time.

My Responsibilities

- I will not record any videoconferencing sessions without written consent from Next Step 2MH, KPMHS or its associates. I understand that Next Step 2MH, KPMHS (or associates) will not record any of our videoconferencing sessions without my written consent.
- I will inform my doctor or counselor if any other person can hear or see any part of our session before the session begins. I understand that my doctor or counselor will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Next Step 2MH, KPMHS or its associates, am responsible for the configuration of any electronic equipment used on my computer which is used for videoconferencing. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- I understand that I must be a resident of a U.S. state in which my doctor and/or counselor is licensed to practice in order to be eligible for videoconferencing services, and that it is my responsibility to inform my doctor and/or counselor of my residency status if it changes at any time in the future.

Patient Consent To The Use of Videoconferencing

I have read and understand the information provided above regarding videoconferencing, have discussed it with my provider and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of videoconferencing in my mental health care and authorize Next Step 2MH, Kentucky Psychiatric and Mental Health Services, PLLC and its associates to use videoconferencing in the course of my diagnosis and treatment.

_____ _____

Signature (Patient/Client or Representative) Date

_____

Printed Name

_____ _____

Printed Name of Representative given authority to act for patient/client Date

Directions to our office:

Our office is located in a convenient, yet discrete and private location behind The Summit Shopping Center, across from Kentucky Country Day School.

If you have any trouble finding our office don't hesitate to give us a call: 502-339-2442