Intensive Outpatient Program Admission Face Sheet

Patient Name: Last: _____ First: _____ Middle: _____
Are you known by any other name? ☐ No ☐ Yes: _____
Mother's Maiden Name: _____
Patient Address: _____
City: _____ State: _____ Zip code: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Date of Birth: _____ Age: _____ Sex: M F Ethnicity: _____
SSN #: _____ Marital Status: S M Legally Sep Div Widow Life Partner
Occupation: _____ Religion: _____
Referral Source: _____ Phone Number: _____

Emergency Contact

Name: _____ Relationship: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Cell Phone #: _____ Work Phone #: _____

Military History

☐ None ☐ Reserves ☐ National Guard ☐ Army ☐ Navy ☐ Marines ☐ Air Force
Dates of Service: _____
Served in Combat: ☐ No ☐ Yes – When? _____
POW: ☐ No ☐ Yes – When? _____
☐ Active ☐ Retired: When? _____ Type of Discharge: _____

Primary Care Physician

Primary Care Physician's Full Name: _____
Address: _____ Phone : _____

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted _____ ☐ Interpreter Refused
(name/number of person/services chosen/used)

Patient Name:_____
DOB:_____
Or label

Name / MR # / Label

Billing Information

I understand that billing my insurance company is an additional service being provided and that it is my responsibility to provide complete and accurate information to aid the billing process. It is my responsibility to keep Novant Health Behavioral Health Outpatient Services and Novant Health UVA Health System Prince William Medical Center (PWMC) aware of any changes or modifications to my insurance coverage. Use of this billing service does not remove my responsibility for any or all charges incurred in treatment.

Patient's Signature	Date/Time	Witness Signature	Date/Time
Signature of Authorized Person (if appropriate)	Date/Time	Relationship to Patient	

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent.

Healthcare Provider Signature	Date/Time

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label

Explanation of Office Policies

We welcome you to Behavioral Health Outpatient Services and assure you that we will provide you the best care possible. This information is intended to provide clarification and prevent future misunderstanding.

Emergency Issues

Should you become suicidal or homicidal or require inpatient detox services, go directly to the nearest emergency room for evaluation. Make sure to give the emergency room the name and number of your Psychiatrist or Therapist. For urgent issues requiring attention of your provider, call the office to leave a message and the provider will call at their first opportunity. Please note the days your provider is in the office.

Scheduled Evaluations

Please note your appointment time carefully. This time is being reserved for you. If you miss an evaluation without calling 48 hours in advance to cancel, you will be charged $100.00. If you miss a session of group treatment, and are a no call, no show, you will be charged $50.00. Keep in mind that insurance companies do not pay for missed appointments/ missed treatment and you will be billed separately for this.

Insurance Coverage

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. Please remember that the insurance benefits are based on a contract between you and your insurance carrier, and **you are ultimately responsible for your account balance should your insurance company deny payment.**

Payment for Services

Non-payment on your account can result in termination of services and referral to another provider. **If your account is referred for collection you will be responsible for collection costs in the amount of 30% of your outstanding balance, together with court costs and attorney's fees.**

Returned Checks

Checks that are returned to Novant Health UVA Health System PWMC are subject to a $25 bank processing charge.

Photo Identification (ID)

The Intensive Outpatient Program reserves the right to refuse services without a valid photo ID.

Changes

When there are changes in your insurance coverage, personal information, or medical history please notify our office on your next visit, or you may call the office to provide such information. Phone number: (703) 369-8404

By signing below I certify that I consent to treatment at Behavioral Health Outpatient Services, and have read and understand the office policies. I agree to pay the fees established by this office or my HMO managed care or insurance plan.

Patient's Signature	Date/Time	Witness Signature	Date/Time
Signature of Authorized Person (if appropriate)	Date/Time	Relationship to Patient	

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent.

Healthcare Provider Signature	Date/Time

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label

Conditions of Admissions for Behavioral Health Outpatient Services Intensive Outpatient Program

1. Admission – Discharge

The undersigned agrees that the treatment of a patient by Novant Health: Behavioral Health Outpatient Services clinician is a matter of clinical judgment and entirely within the discretion of the attending provider; that the Behavioral Health Outpatient Services admits the patient with the understanding that it reserves the right, at any time, to discharge the patient for any reason that may be satisfactory to the Behavioral Health Outpatient Services.

2. Assignment of Insurance Benefits

In the event that the undersigned is entitled to benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any other party liable to the patient, said benefits are hereby assigned to Novant Health UVA Health System Prince William Medical Center for application on the patient's bill. It is agreed that Novant Health UVA Health System Prince William Medical Center may make receipt for any payment and such payment shall discharge the insurance company of any obligations under the policy to the extent of such payment, the undersigned and/or patient being responsible for such charges not covered by this agreement.

3. Financial Agreement

The undersigned agrees, whether he signs as agent or as a patient, that in consideration of the services to be rendered to the patient, he hereby individually obligates himself to pay all charges incurred by Novant Health UVA Health System Prince William Medical Center for or in connection with treatment of the patient or cost related thereto in accordance with the regular rates and terms of Novant Health UVA Health System Prince William Medical Center. Should the patient's account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the legal rate. The undersigned further agrees to pay the fair market value for all furniture, equipment and property that may be broken or damaged by the patient. It Is understood and agreed that the undersigned are jointly and severally primarily liable hereunder and no demand or claim against the patient or the patient's estate for the amount due, and no attempt to collect therefrom, need to be made to render me/us liable hereunder.

The undersigned authorizes that they have read the above and is the patient, or is duly authorized by the patient to execute these conditions and to accept these terms.

Patient's Signature	Date/Time	Witness Signature	Date/Time
Signature of Authorized Person (if appropriate)	Date/Time	Relationship to Patient	

I have discussed the issues above with the client (and/or his or her parent/legal guardian, or other representative). My observations of this person's behavior and responses give me no reason to believe that this person is not fully competent to give informed or willing consent.

Healthcare Provider Signature	Date/Time

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label

As a client served in the Behavioral Health Outpatient Services, you have specific rights. The purpose of this form is to inform you of your rights as our client.

I. Right to Voluntary Services

You have the right to request voluntary services.

You have a right to:

- Have a staff person assigned specifically to work with you in resolving your problems and ensuring that your service is properly provided
- A personal, individualized assessment of your needs
- An individualized service plan, which will be reviewed regularly, developed with your input, and implemented with your consent
- Services beginning within a reasonable time and ending when they are no longer needed or effective
- Another opinion regarding services provided (However, seeing someone outside of this setting is done at your own expense)
- Referrals to other competent professionals and sources of help as indicated by your service plan
- Terminate service if your circumstances require it or you feel it is in your best interest, unless doing so puts you or others in grave danger
- Resume services following termination
- File a grievance if you feel your rights have been denied or violated. The Behavioral Health contact for filing a grievance is Dept. Director at (703) 369-8883. The Regional Human Rights Advocate at (877) 600-7437 is available as well to discuss Human Rights Violation issues

II. Right to Refuse Services

You have a right to:

- Refuse any form of service or treatment unless it has been ordered by the court or in emergency situations when necessary to prevent harm to yourself and others (If you must receive services not by your own choice, you have the right to a lawyer, a court hearing, and an appeal of the decision to a higher court. If you cannot afford a lawyer, the court will appoint one for you.)
- Refuse service with your primary clinician and request another practitioner in this setting or a referral to another setting
- Be informed that without services, your situation may worsen
- Refuse to be filmed or audio taped without your written permission
- Refuse to take part in research studies without your written permission

III. Right to Confidentiality / Privacy

All information about you is understood to be confidential to protect your privacy. This information includes the fact that you have or have not received services. All professionals and other staff associated with this setting are obligated to preserve your privacy to the extent permitted by law.

You have a right to:

- Determine the amount of information to be released, whether to or from anyone outside this setting, by signing a consent form
- Sign a consent form to release information that is specific to each situation when information is to be released (You will not be asked to sign a "blanket" consent for release of information.)
- Determine the length of time that information may be released and cancel your permission at any time (However, information may be released without your permission in a medical emergency to save lives, to prevent injury to yourself or others, or when required by law or ordered by the court.)

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label

IV. Right to a Humane Mental and Physical Environment

You have a right to:

- Courtesy, respect, and professionalism from everyone involved in your service in this setting
- Facilities that are comfortable and safe, promote dignity, ensure privacy, and contribute to positive outcomes of your service.

V. Right to Information

You have a right to verbal and written information about:

- Your rights, role, and responsibilities as a patient in this setting
- Your primary clinician's rights, role, and responsibilities in this setting
- What you can expect during your service process-appointment, cost, handling of emergencies, and other practices and procedure of this setting as they affect you
- Your primary clinician's credentials and professional code of ethics
- Means to contact your primary clinician in both emergency and non-emergency situations
- The name of and means to contact your primary clinician's supervisor
- Procedure for reviewing your clinical records

VI. Rights Pertaining to Medication

You have a right to:

- The administration of medication only under the written order of a physician
- A complete explanation, in language you can understand, of the purpose of any medication, possible side effects, and possible results of long-term use
- Full consideration of your opinions and reactions to the medications
- A regular review of your medication for the purpose of adjustment, as a check for possible side effects, and for possible reduction or elimination
- Have accurate records kept noting your medication history, including any adverse reactions or drug allergies
- Have medication prescribed for you only when necessary

Patient Signature: _____ Date: _____ Time: _____

Patient Name:_____

DOB:_____

Or label

Name / MR # / Label