



Patient Information Form

Brent Menninger, M.D.
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Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: "M" "F

Preferred Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone # (for reminder calls): \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Employment Status: Full Time Part Time Not Working Student (RlemOne)

Marital Status: Single Married Divorced Widowed Separated (RlemOne)

Parent (s) Name (if minor)

Mother: \_\_\_\_\_ Phone: \_\_\_\_\_

Father: \_\_\_\_\_ Phone: \_\_\_\_\_

Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

Spouse (if married): \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Insurance Carrier

Insurance Name: \_\_\_\_\_ Insurance Phone Number: \_\_\_\_\_

Address for Medical Claims: \_\_\_\_\_

Member ID#: \_\_\_\_\_ Group #: \_\_\_\_\_

Name of Policy Holder (Subscriber): \_\_\_\_\_ Subscriber's SS#: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_ Subscriber's Phone# \_\_\_\_\_

Patient's Relationship to Subscriber: Self Spouse Dependent (RlemOne)

How did you hear about our practice? \_\_\_\_\_

I authorize the release of any information necessary to process insurance claims and to obtain reimbursement. I request that payment of authorized benefits be made on my behalf to this practice. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges not paid by my insurance. Some insurance companies pay a fixed amount; others pay a percentage of the charge. We will estimate your co-pay for services rendered at the time of service. It is your responsibility to pay any deductible, co-pay or balance not paid by your insurance company.

Patient's Signature (or Legal Guardian Signature)

Date

## PCA FINANCIAL POLICY

The following is a statement of our Financial Policy which we require you to read, initial letters **A** through **H** and sign prior to receiving any treatment from our providers.

\_\_\_\_ (A) Thank you for choosing us as your behavior healthcare provider. Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between **you and your insurance company**. It is your responsibility to know your insurance policy benefits. We are not always informed of your specific contract. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance or other matters regarding reimbursement.

### Insurance and Fee Policy

\_\_\_\_ (B) As a courtesy, we will verify and submit your insurance claim to a primary insurance plan only. We do not bill to secondary or third party insurance. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under your insurance. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted providers. **You are responsible for providing this office with copies of your insurance card or any changes with your insurance or coverage prior to being seen by one of our providers.** Failure to do so may result in a denial of your claim making you financially responsible for your sessions(s). If you do not have insurance, we offer a discounted rate due at the time of service.

### 24-Hour Cancellation Policy

\_\_\_\_ (C) You will be charged for every scheduled appointment unless you cancel at least **24 hours in advance**. Late cancellation or no shows will be billed at the rate of \$50.00 for a medication check and \$75.00 for a 30 minute or longer appointment. Insurance companies will not pay for no shows or late cancellation charges. Those are your responsibility before you can be rescheduled for another appointment.

### Appointment Reminders

\_\_\_\_ (D) We will make a courtesy reminder call and/or text and/or send an e-mail 48-hours prior to your scheduled appointment. Ultimately, keeping scheduled appointments is your responsibility.

### Returned Check Fee

\_\_\_\_ (E) There is a \$45.00 fee for any check returned unpaid by your bank. You will have 10 days to clear up the outstanding check, otherwise it will be sent to our collection agency. Your account will be placed on a cash or credit card only basis, as we will no longer accept checks from you.

### Payments and Collections

\_\_\_\_ (F) We accept cash, checks, Visa, MasterCard, Discover and American Express and recommend keeping your credit card on file. Any outstanding balances are due within 30 days of the statement, after which a \$5.00 fee will be added to your account. If you experience circumstances beyond your control, please speak with your clinician or the billing department for payment arrangements. All balances reaching 90 days past due may be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance. Please be aware if your past due status is reported to a collection agency and /or a credit reporting agency, the fact you received treatment at our office may be a matter of public record.

### Medical Records/Paperwork/Prescription Refill Fees

\_\_\_\_ (G) There may be times when you may need medical records, paperwork or prescription refills completed by one of our providers. There is a fee for filling out these requests. The fees vary according to the document(s) needed. Medical Records may take up to 60 days, paperwork up to 10 days and prescription refills 3 days.

### Divorce

\_\_\_\_ (H) If you have been or are now involved in a divorce, please understand that we are legally not part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree. We encourage all legal guardians to be present at all appointments for minor children.

Printed Name of Person Financially Responsible (Guarantor) \_\_\_\_\_

\_\_\_\_\_  
Signature of Guarantor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address of Guarantor (where statements will be mailed)

\_\_\_\_\_  
Social Security # of Guarantor

Date of Birth of Guarantor: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Guarantor's Phone # \_\_\_\_\_

## CREDIT CARD ON FILE AGREEMENT

Psychiatric & Counseling Associates recommends keeping your credit or debit card on-file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Your credit card information is kept confidential and secure. An example of your liability is a deductible amount that insurance applies to your responsibility after they process the claim. Payments to your card are processed after the claim has been filed and processed by your insurer, and the insurance portion of the claim has paid and posted to the account. Whenever a payment is processed you will receive a credit card receipt by email. If you choose not to keep your credit card on file, your first statement is mailed at no charge. If a second statement is required to settle the account, a billing fee of \$5.00 will be added to your account.

**I authorize Psychiatric & Counseling Associates to charge the portion of my bill that is my financial responsibility to the following credit or debit card:**

**Amex          Visa          MasterCard          Discover**

**Credit Card Number** \_\_\_\_\_

**Expiration Date** \_\_\_\_ / \_\_\_\_ / \_\_\_\_ **Security Code (CVV)** \_\_\_\_\_

**Cardholder Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

**Email** \_\_\_\_\_

**Billing Address** \_\_\_\_\_

**City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip** \_\_\_\_\_

I (we), the undersigned, authorize and request Psychiatric & Counseling Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility, or other self-pay balances that accumulate on the account. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric & Counseling Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30-day notification to Psychiatric & Counseling Associates in writing.

**Patient Name (Print):** \_\_\_\_\_

**Patient or Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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I, (print name) \_\_\_\_\_ decline to keep my credit card on file, and I understand that any balance over 30 days past due will incur an additional \$5.00 charge for our office to continue collection efforts. Any balance over 90 days past due may be sent to collections.

**Patient Name (Print):** \_\_\_\_\_

**Patient or Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## CONSENT FOR TREATMENT

I hereby voluntarily consent to receive services, which may include assessment, and referral recommendations deemed necessary and advisable in the judgment of Psychiatric & Counseling Associates, LLC. If the patient is a minor or otherwise incapable of providing consent, I hereby authorize and consent to the same services for him/her. I understand that the information given to Psychiatric & Counseling Associates, LLC., will be kept confidential and will only be released when: a written consent is obtained, a medical emergency occurs, a court order or subpoena is received; information is required by the insurance company and/or managed care firm to process claims and manage treatment; or a patient represents a serious danger to himself/herself or others. I hereby hold harmless Psychiatric & Counseling Associates, LLC., for any loss, costs, and damages allegedly sustained by me or my ward because of the release of information under the circumstances listed above.

I give my consent for PCA clinicians and staff to leave a message regarding scheduling, treatment, lab results, billing, or other information as necessary. **(Check all that apply):**

On an answering machine or voicemail at home or on cell

On an answering machine or voicemail at work

With a specific individual: \_\_\_\_\_

Any e-mail you provided us (Ex: We may try emailing if your voicemail box is full or if you request a statement be emailed to you, etc.)

**I do not consent to messages left at home, work or with any person. I wish to be contacted directly.**

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Responsible Party  
Who is NOT living with the minor

\_\_\_\_\_  
Date

## COORDINATION OF CARE BETWEEN HEALTHCARE PROVIDERS AND RELEASE OF INFORMATION

Communication between behavior health (BH) providers and your primary care physician (PCP) and other BH providers/facilities, is important to make sure you receive comprehensive and quality care. This form will allow your BH provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. PHI may include your diagnosis, treatment plan, progress, and medications.

### Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request. This consent does not expire unless a request to revoke my consent is given.

**My PCA provider is authorized to release PHI related to the evaluation and treatment of**

(Patient Name) \_\_\_\_\_ to Provider(s) \_\_\_\_\_

\_\_\_\_\_  
(Signature of Patient or Responsible Party)

Date: \_\_\_\_\_



**Brent Menninger, M.D.**  
**Nancy Pierce, APRN**  
**Diane Gaunt, APRN**  
**Andrea Gerry, LCMFT**  
**Darcy Lane, LFMT**  
**K Bryce Jones, LMFT**

## Authorization for Disclosure of Information

1. I hereby authorize free communication and disclosure between:

\_\_\_\_\_

and \_\_\_\_\_

2. Name of Client:

\_\_\_\_\_

3. Maiden Name:

\_\_\_\_\_

4. Date of Birth:

\_\_\_\_\_

5. Social Security Number: \_\_\_\_\_

6. The purpose or need for disclosure is:

\_\_\_\_\_

\_\_\_\_\_

7. I hereby authorize and direct that both parties named in one (1) above may discuss in person or by telephone or in writing any information in their possession relative to the above-named client.

8. This authorization may be revoked by me at any time, except to the extent that action has been taken in reliance therein. This authorization, unless expressly revoked earlier, will expire on:

Expiration Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Notice of Privacy Practices

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**This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.**

### **To Our Patients:**

Our office holds all your health information confidential. We are required, by law, to keep your health information private and provide you with this Notice of Privacy Practices. This Notice of Privacy Practice explains how Psychiatric and Counseling Associates, LLC (PCA) and its clinical staff and employees may share your Protected Health Information (PHI) with others for treatment, payment, health care operations, and other purposes allowed or required by law. This Notice of Privacy Practices is posted on our web site ([www.pca4u.com](http://www.pca4u.com)) and is also available at the front check-in location.

**Protected Health Information (PHI)** is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

**Healthcare Operations** include activities such as discussions between PCA staff and other health care providers, training clinic staff, interacting with insurance companies, carrying out medical reviews to measure quality, and managing business functions.

PCA uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. Examples of which are listed below:

- Provide PHI to referring providers to create and carry out a plan for your treatment.
- Provide PHI to your insurance company to file claims for payment.
- May use PHI to review the quality of services you receive.
- May send you reminders for appointments.
- May share PHI with public health agencies as permitted by law.
- Will use and disclose PHI when required by federal or state law, or by court order. For example, to investigate reports of abuse.
- May use and disclose PHI for public benefits under other government programs.
- May disclose PHI to law enforcement in order to avoid serious threat to the health safety of a person or the public.
- May disclose PHI to your family or other persons who are officially involved in your medical care. You have the right to object to the sharing of this information.

To release patient PHI to other people for any reason other than treatment, payment, and health care operations (described above) or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly authorizes how you (the patient) wish the information to be used and disclosed.

## **Your Rights Regarding Your Health Information**

***Right to see and get copies of your records.*** In most cases, you have the right to review or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

***Right to request a correction or update to your records.*** You may ask PCA to change (amend) or add missing information to your records if you think there is a mistake. Your request must be made in writing to the Office Manager. In certain cases, we may deny your request for change.

***Right to get a list of disclosures.*** You have a right to ask PCA for a list of disclosure(s) made after April 14, 2003. This is a list of the disclosures we made of medical information about you, other than for treatment, payment or healthcare operations as described in the Privacy Notice. We are not required to account for information releases: that you requested, that you agreed to by signing an Authorization Form, that are given to family or friends involved in your care or certain releases we are allowed to make without your permission. The request for a record must be made in writing to the Office Manager. The request should state the time period for the list. Requests for records about PCA disclosures of your PHI are limited to time frames of six years or less as required by law.

***Right to request limits on uses or disclosures of PHI.*** You have the right to ask that PCA limit how your information is used or disclosed for the purposes of treatment, payment, and healthcare operations. You must make the request in writing telling PCA what information you want to limit and to whom you want the limits to apply. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for your treatment completely out of pocket, you can request for PCA not to provide information about your treatment to your insurance company.

***Right to revoke permission.*** If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

***Right to choose how we communicate with you.*** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must request in writing to the Office Manager. Your request must specify how or where you wish to be contacted. We will not ask you the reason for the request. We will attempt to accommodate all reasonable requests.

***Right to get a paper copy of this notice.*** You have the right to ask for a paper copy of this notice at any time.

**Complaints:** You may submit any complaints with respect to violations of your privacy rights to the PCA Office Manager. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from PCA for making a complaint.

**Change to this Notice:** If we make a material change to this Notice, we will provide a revised Notice available at [www.pca4u.com](http://www.pca4u.com).

**Contact Information:** Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the Office Manager at 913-327-7505.

## Patient Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy will be posted in the practice's office, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date

If not signed by the patient, please indicate relationship:

\_\_\_\_\_ Parent of guardian of minor patient

\_\_\_\_\_ Guardian or conservator of incompetent

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that we provide you with this notice that explains our privacy procedures with regard to your medical information and how we may use and disclose your Protected Health Information (PHI) for treatment, payment, and for care operations, as well as purposes that are permitted or required by law. You have certain rights regarding the privacy of your PHI, and we also describe them in this notice.



## Medical Information Sheet

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer/School: \_\_\_\_\_

Family Members in Household: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

What is the date of your last physical examination? \_\_\_\_\_

What is the name of your Primary Care Physician (PCP)? \_\_\_\_\_

Do you have or have you had any of the following:

Condition	Y	N	Please Explain
Heart Problems			
Neurological Problems (Numbness, weakness, headaches, paralysis)			
Seizures			

Have you had previous outpatient mental health treatment? If yes, please let us know when and where. \_\_\_\_\_

Have you been an inpatient at a hospital/institution for psychiatric treatment? If yes, please let us know the reason for admission, location and the date(s) of your treatment. \_\_\_\_\_

*Continued on Back of Page*

**Current Medications** (include prescriptive, herbal and over-the-counter medications)

Name	Dosage & Frequency	Dates of Use	Prescribing Physician

**Past Psychiatric Medications**

Please review the following list of commonly prescribed psychotropics. Both the trade names and generic names are provided in an effort to aid in your recall. Please **check** all that you have been on in the past. Also, **circle** the ones that you feel were particularly helpful and **underline** any that caused you side effects.

Viibryd / vilazodone Particularly helpful Caused side effects	Saphris / asenapine Particularly helpful Caused side effects	Campral / acamprosate Particularly helpful Caused side effects
Prozac / fluoxetine Particularly helpful Caused side effects	Fanapt / iloperidone Particularly helpful Caused side effects	Antabuse / disulfiram Particularly helpful Caused side effects
Paxil / paroxetine Particularly helpful Caused side effects	Thorazine / chlorpromazine Particularly helpful Caused side effects	Revia / naltrexone Particularly helpful Caused side effects
Zoloft / sertraline Particularly helpful Caused side effects	Mellaril / thioridazine Particularly helpful Caused side effects	Ambien / zolpidem Particularly helpful Caused side effects
Celexa / citalopram Particularly helpful Caused side effects	Prolixen / fluphenazine Particularly helpful Caused side effects	Sonata / zaleplon Particularly helpful Caused side effects
Lexapro / escitalopram Particularly helpful Caused side effects	Trilafon / perphenazine Particularly helpful Caused side effects	Lunesta / eszopiclone Particularly helpful Caused side effects
Luvox / fluvoxamine Particularly helpful Caused side effects	Stelazine / trifluoperazine Particularly helpful Caused side effects	Somnote / chloral hydrate Particularly helpful Caused side effects
Wellbutrin / bupropion Particularly helpful Caused side effects	Haldol / haloperidol Particularly helpful Caused side effects	Restoril / temazepam Particularly helpful Caused side effects
Serzone / nefazodone Particularly helpful Caused side effects	Navane / thiothixene Particularly helpful Caused side effects	Halcion / triazolam Particularly helpful Caused side effects
Effexor / venlafaxine Particularly helpful Caused side effects	Loxitane / loxapine Particularly helpful Caused side effects	Prosom / estazolam Particularly helpful Caused side effects
Remeron / mirtazapine Particularly helpful Caused side effects	Moban / molindone Particularly helpful Caused side effects	Dalmane / flurazepam Particularly helpful Caused side effects
Desyrel / trazadone Particularly helpful Caused side effects	Eskalith / Lithobid / lithium Particularly helpful Caused side effects	Rozerem / ramelteon Particularly helpful Caused side effects
Elavil / amitriptyline Particularly helpful Caused side effects	Depakote / divalproex Particularly helpful Caused side effects	Xanax / alprazolam Particularly helpful Caused side effects

Anafranil / clomipramine Particularly helpful Caused side effects	Tegretol / Carbatrol / carbamazepine Particularly helpful Caused side effects	Klonopin / clonazepam Particularly helpful Caused side effects
Sinequan / doxapine Particularly helpful Caused side effects	Lamictal / lamotrigine Particularly helpful Caused side effects	Valium / diazepam Particularly helpful Caused side effects
Tofranil / imipramine Particularly helpful Caused side effects	Trileptal / oxcarbazepine Particularly helpful Caused side effects	Tranxene / clorazepate Particularly helpful Caused side effects
Cymbalta / duloxetine Particularly helpful Caused side effects	Keppra / levetiracetam Particularly helpful Caused side effects	Librium / chlordiazepoxide Particularly helpful Caused side effects
Norpramin / desipramine Particularly helpful Caused side effects	Topamax / topiramate Particularly helpful Caused side effects	Ativan / lorazepam Particularly helpful Caused side effects
Pamelor / nortriptyline Particularly helpful Caused side effects	Gabitril / tiagabine Particularly helpful Caused side effects	Serax / oxazepam Particularly helpful Caused side effects
Nardil / phenelzine Particularly helpful Caused side effects	Neurontin / gabapentin Particularly helpful Caused side effects	Ritalin / Concerta / Metadate / Daytrana / Focalin / Focalin XR / Methylphenidate Particularly helpful Caused side effects
Parnate / tranylcypromine Particularly helpful Caused side effects	Buspar / buspirone Particularly helpful Caused side effects	Adderall / Adderall XR / Vyvanse Particularly helpful Caused side effects
Eldepryl / selegiline Particularly helpful Caused side effects	Inderal / propranolol Particularly helpful Caused side effects	Dexedrine / dextroamphetamine / Amphetamine Particularly helpful Caused side effects
Risperdal / risperidone Particularly helpful Caused side effects	Catapres / clonidine Particularly helpful Caused side effects	Cylert / pemoline Particularly helpful Caused side effects
Zyprexa / olanzapine Particularly helpful Caused side effects	Atarax / Vistoril / hydroxyzine Particularly helpful Caused side effects	Strattera / atomoxetine Particularly helpful Caused side effects
Seroquel / quetiapine Particularly helpful Caused side effects	Equinil / Miltown / meprobamate Particularly helpful Caused side effects	Provigil / modafinil Particularly helpful Caused side effects
Geodon / ziprasidone Particularly helpful Caused side effects	Tenormin / atenolol Particularly helpful Caused side effects	Nuvigil / armodafinil Particularly helpful Caused side effects
Abilify / aripiprazole Particularly helpful Caused side effects	Tenex / Intuniv / guanfacine Particularly helpful Caused side effects	Exelon / rivastigmine Particularly helpful Caused side effects
Clozaril / clozapine Particularly helpful Caused side effects		Reminyl / galantamine Particularly helpful Caused side effects
Latuda / lurasidone Particularly helpful Caused side effects		Aricept / donepezil Particularly helpful Caused side effects

Patient's/Guardian's Signature: \_\_\_\_\_

Date: \_\_\_\_\_