Izzy Health PLLC

You are most welcome to Izzy Health psychiatric services. We are glad to assist you on your journey to recovery. We will help you overcome any challenges you may encounter, including addressing any concerns about your care. Let's find Hope where there appear to be none.

CONFIDENTIALITY

The information you share with us is strictly confidential. The psychiatrist/therapist will not release any information about your treatment unless:

You or a family member being treated presents as imminent danger to self or others

Suspicions of abuse/neglect

Specific requests from a judge or if the notes are subpoenaed by a court of law

If multiple family members receive services, there may be case collaboration with our clinical staff to aid treatment

It is agreed upon in writing, complies with State Laws or as a necessity for continuity of care such as interactions with your primary care provider, counselors or other medical practices.

I understand that for the purpose of reimbursements, my medical information will be released to insurance companies. I also understand that in cases of danger to self/others or cases of abuse/neglect, Izzy Health PLLC is required by law to inform potential victims and legal authorities to ensure protective measures are taken. I acknowledge that I have received a copy of Izzy Health PLLC Notice of Privacy Practices. If I have any questions regarding confidentiality, I am aware I can contact the Privacy Officer at 3365498334

CONSENT TO RELEASE OF INFORMATION

I consent to information release for the evaluation and treatment of my dependent or myself. I fully understand this release of information may be with the source of referral and other co-treating health care facilities for the purpose of treatment. This includes but is not limited to my primary care provider, counselors, inpatient facilities or other medical providers. I authorize that providers of Izzy Health PLLC may disclose information regarding my treatment and this may include information related to mental health status, drug and alcohol abuse, HIV status and other sexually transmitted diseases. I understand I can revoke this authorization strictly in writing. I am aware however that such revocation may render treatment ineffective and my providers may elect to transfer my care to another qualified professional.

PRACTICE POLICIES

Please carefully review the following information about our practice policies. Your understanding of these policies will help us work most effectively with you.

OFFICE HOURS: Monday through Friday, 9:00am to 6:00pm. Our office is closed on all major holidays.

APPOINTMENTS AND APPOINTMENT CANCELLATIONS: Our goal is for appointments to begin promptly as scheduled. New evaluations are scheduled for 45 minutes and our follow up appointments are 15 minutes long. We strongly recommend you fill out your forms prior to your appointments. We also encourage you arrive at least 10 minutes before your scheduled time. If you are late, this will cut into your appointment time. Please notify the office of appointment changes or cancellations as far in advance as possible to allow another client to utilize the time.

You agree that failure to cancel an appointment at least 24 hours in advance will result in your credit card on file being charged $70 as we are unable to bill insurance companies for missed appointments. The above is subject to change.

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Clients experiencing crisis are advised to contact the National Suicide Prevention Lifeline (1-800-273-8255) or attend the nearest Emergency Room.

FEES: Insurance co-payments, deductibles and co-insurance if any, are due at the time of scheduled appointment. We accept cash, check, debit or credit cards. I hereby authorize my insurance benefits to be paid directly to Izzy Health PLLC and I recognize my responsibility to pay for all non-covered services, including any additional cost incurred in collecting these amounts.

I also authorize Izzy Health PLLC to release any information necessary to process my insurance claim. In the event that my insurance fails to make a payment to Izzy Health PLLC, I understand that I am ultimately responsible for the fees and this will be charged to my credit card.

I understand that if I choose to self-pay, payment is also due on the day of the appointment. Our fees are $200-$300.00 for a new evaluation and $100-$200 for follow up. There is a $35.00 fee for bounced checks and a $20.00 fee for declined credit cards, which will be added to fees charged.

I understand that if I fail to pay for the services received, my services may be terminated, all billing information including name, address, place of employment, dates of service received,

etcetera, may be given to a professional collection agency to use in their process of collection. I further understand that if my account is placed for collection, I will be responsible for the fee charged by the collection agency and any attorney or court fees assessed.

PHONE CALLS/EMAILS:

We return phone calls strictly during office hours. Non-urgent phone calls are returned within 48 business hours. We do not accept after hours phone calls. For emergencies, please call 911 or attend the nearest Emergency Room. Except in extreme situations, we advise contact be restricted to session time as our providers are always busy seeing scheduled clients. In view of this, phone calls may be charged based on the time spent per call.

PRESCRIPTION POLICY: We would send all prescriptions electronically. In the event you need refills, please give us a call within a week of running out. Give us 48 hours to respond.

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LABORATORY: We may need to order laboratory tests in some cases, especially if prescribed controlled substances. The cost of labs is not included in your visit charge. You must ask the laboratory about their costs and make payments accordingly.

TESTIFYING IN COURT: Our providers DO NOT testify in court. If we are however requested or subpoenaed to provide testimony, such as in a custody case, you will be financially responsible even though the subpoena is sent from the opposing side of this case. This holds true whether the client is active with our providers or if the relationship has ended. We will require travel expenses be paid as well as a fee for preparation, research, travel and appearance for the case. Fees will be agreed on when requested.

TERMINATION POLICY: Clients may terminate services at any time. We also reserve the right to terminate treatment for clients who miss 3 consecutive appointments, non compliant with treatment and if there are no services delivered for 90 days or more, unless special arrangements for less frequent visits have been made. Grounds for termination include issues with controlled medications involving running out too early repeatedly, losing the medications, giving away medications, getting refills from different providers etcetera. I acknowledge controlled medications will be monitored via NC Prescription Monitoring Program. During your initial visit, we will determine your needs and offer a plan of care to suit you, you should consider this but if not satisfied, we are glad to help refer you to another provider.

POLICY ACCEPTANCE: The providers of Izzy Health PLLC are committed to providing you with exceptional services in a professional manner. Your agreement to our policies will enable provision of such care. We look forward to working with you.

AGREEMENT FOR SERVICES

I have read through the confidentiality, consent, practice polices, notice of privacy practices and have had the opportunity to clarify unclear issues with providers of Izzy Health PLLC. I agree to enter a medical/counseling relationship with Izzy Health PLLC PA.

I also agree to be charged $70 if I fail to cancel an appointment at least 24hrs in advance as insurance companies do not pay for missed appointments.

_____

Signature of Client/Guardian Date

_____

Printed Name of Client/Guardian Date

_____

Witness Date

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CONSENT FOR TREATMENT OF AN ADULT

I hereby authorize Izzy Health PLLC to conduct evaluations, diagnosis, treatment, medical procedures and/or psychological testing based on the professional recommendations of my

psychiatrist/therapist. I understand that such procedures provided by Izzy Health PLLC psychiatrists, therapists or ancillary staff would be subject to my agreement.

_____

Client/Legal Representative Date

_____

Witness Date

CONSENT FOR TREATMENT OF A DEPENDENT

I hereby certify that I am the legal guardian of this patient and legally authorize Izzy Health PLLC PA to provide mental health care to the above named. I am aware that such care may include evaluations, diagnosis, treatment, medical procedures and/or psychological testing provided by Izzy Health PLLC psychiatrists, therapists or ancillary staff.

_____

Client/Legal Representative Date

_____

Witness Date

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Client Information

Name: _____ Date: _____

If dependent, guardian name: _____

Address: _____ City: _____State: _____Zip: _____

Phone Number: _____ Email address: _____

Permission to leave voicemail: Yes or No Permission to contact by text: Yes or No

Date of Birth: _____ Age: _____ Gender: _____

Marital Status: _____

Emergency Contact

Emergency Contact Name: _____Phone Number: _____

Relationship to Patient: _____

In the case of an emergency, do we have your permission to contact the person listed above: Yes or No

Insurance Information

Name of Insurance Company: _____

Name of the Subscriber: _____

Relation to Subscriber: _____ Subscriber DOB: _____

Insurance ID Number: _____ Group Number: _____

Address of Subscriber (if different from above): _____

City: _____ State: _____ Zip: _____

Place of Employment of Subscriber: _____

Insurance Company Phone Number: _____

Izzy Health PLLC

Psychosocial Assessment

Name: _____Date: _____

Presenting Problem: _____

_____

_____

Existing Medical Conditions: _____

_____

Previous Mental Health Diagnosis: _____

_____

Previous Mental Health Admissions: _____

_____

Previous Psychiatric Medications: _____

_____

List of Current Medications: _____

_____

_____

Use of Tobacco, Alcohol or Drugs (please specify): _____

_____

Allergy to Medication: _____

_____

Any Physical, Sexual or Emotional abuse? (Please specify): _____

_____

Any Family History of Mental illness, Substance abuse or Suicides? _____

_____

Highest level of education_____

Employment (if applicable) _____

_____

Name of provider for last prescriptions: _____

Patient Health Questionnaire – 9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Not at all

Several Days

More than half the days

Nearly every day

1. Little interest or pleasure in doing things

0

1

2

3

2.Feeling down, depressed, or hopeless

0

1

2

3

3.Trouble falling or staying asleep, or sleeping too much

0

1

2

3

4.Feeling tired or having little energy

0

1

2

3

5.Poor appetite or overeating

0

1

2

3

6.Feeling bad about yourself – or that you are a failure or have let yourself or your family down

0

1

2

3

7.Trouble concentrating on things, such as reading the newspaper or watching television

0

1

2

3

8.Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual

0

1

2

3

9.Thoughts that you would be better off dead or of hurting yourself in some way

0

1

2

3

TOTAL:

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all | Somewhat difficult | Very difficult | Extremely difficult

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Payment of Services Agreement

We accept cash, check, debit and credit cards.

I understand that if my dependent or I do not show up for a scheduled appointment or if I cancel a scheduled appointment with less than 24 business hours, my credit card will be charged $70.00 according to our late cancellation/no shows policy. The same credit card will be used when necessary to charge for providing reports, forms, letters, phone calls, etc.In addition, in the event that my insurance company does not pay the allowable fees, as indicated medically necessary, I understand this credit card will be charged the allowable amount.

I authorize Izzy Health PLLC to charge my credit/debit card as indicated below:Type of Card: _____

Credit Card Number: _____

Name as it appears on Card: _____

Expiration Date: _____ Security code: _____ Zip Code: _____ Client Name: _____Cardholder Name: _____

Cardholder Signature: _____ Date: _____