Gilead Psychiatric Services
59 Stiles Road, Salem, NH, 03079
Phone # 603-458-6681
Fax# 603-458-6919

Patient Information

Date :_____

Patient's Last Name: _____**First name:** _____

MI: _____

Patient's DOB: _____ **Age:** _____ **Male** _____**Female** ____

Mailing Address:

_____

City: _____**State:** _____ **Zip:** _____

Home Phone: _____ **Work:**_____**Cell :**_____

Okay to leave message Y N **Okay to leave message Y N Okay to leave message Y N**

Email address : _____

Emergency Contact Name: _____**Relationship to patient:**_____

Emergency Contact Phone : _____

Name of Primary Care Physician (PCP):

_____

Phone Number of PCP: ( )

_____

Emergency Contact:

Name:_____

Relationship: _____**Phone: ( )** _____

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INSURANCE INFORMATION: (please have card ready to be photocopied)

Name of Insurance Company:

_____

ID #: _____ **Group #:**

_____

Address: _____

_____

Relationship to Policy Holder: Self _____ Spouse _____ Child: _____ Other:

_____

Policy Holder's Name: _____**Policy Holder's DOB:** _____

Policy Holder's Address:

_____

_____

Outpatient Mental Health Authorization Needed: Y N Copay: _____ Deductible:

_____

If applicable, secondary payor or insurance company:

_____

ID #: _____ **Group #:**

_____

Claim Address:

_____

_____

Relationship to Policy Holder: Self _____ Spouse _____ Child: _____ Other:

_____

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Policy Holder's Name: _____Policy Holder's DOB: _____

Policy Holder's Address:

_____

_____

Outpatient Mental Health Authorization Needed: Y N Copay: _____ Deductible: _____

Name of Primary Care Physician: _____

Address:_____

_____

Phone Number of PCP : _____

Fax Number of PCP : _____

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Medical/ Surgical/Psychiatric History

Patient name : _____ DOB: _____

Date of Last Physical Exam:_____

Please list any current/chronic medical conditions/Surgeries

_____

_____

_____

_____

_____

Please list any current medications you are taking with dose and frequency

_____

_____

_____

_____

_____

_____

_____

_____

Please list ant past Psychiatric medications you have taken and response to those medications.

_____

_____

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Please list any medication or food allergies and type of reactions

Please list any Psychiatric hospitalizations

Please list any family history of mental health illness

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Permission to Share Information

I, ---------- allow Gilead Psychiatric Services to share information with the following family member(s) or friends

1.----------Phone #----------

2. ---------- Phone #----------

for coordinating my treatment and care.

I understand that I can change this agreement at any time. When it is necessary, I will do so in writing.

Patient signature _____

Printed Patient Name _____-

Date _____

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Electronic Communication Consent

Patient name: ----------

Date of Birth: ----------

Patients of Gilead Psychiatric services may be contacted via email or text message to remind them of an appointment.

I, ————(Client initials) consent to receive text messages from Gilead Psychiatric services at my cell phone or email address to receive communications as stated above. This request will apply to all future appointment reminders unless a change is requested in writing.

The Cell Phone number I authorize to receive text messages for appointment reminders or scheduling is ————————

The email address that I authorize to receive email messages for appointment reminders or scheduling information is ————————

Emails and Texts will only be used for appointment related information and for reminders and should not be used for refill requests or clinical questions or concerns. Standard text messaging rates may apply as provided in your wireless plan (please contact your carrier for details)

Client Signature ---------- Date----------

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Consent to Treat Form

1. I _____give Gilead Psychiatric Services permission to provide me medical treatment.

2. I allow Gilead Psychiatric Service to file for insurance benefits to pay for the care I receive.

   I understand that:
   Gilead Psychiatric Services will have to send my medical record information to my insurance company. I must pay my share of the costs. I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

3. I understand that:
   I have the right to refuse any medication or treatment.
   I have the right to discuss all medical treatments with my clinician.

_____ _____
Patient's Signature Date

_____ _____
Print name Date

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Financial Policy and Agreement

Patient name: …… Date of Birth: …….

Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment. It is your responsibility to determine if you require a referral, prior authorization or limited number of visits, copayment, or deductible. Payment is expected at the time of the visit. Co-payments and co-insurances are due at the time of service. Clients with prior balances are expected to pay before the provision of services. Cash, checks, debit card, credit cards, HSA etc. are accepted as forms of payment. Please write checks payable to Gilead Psychiatric Services. Please note that there will be a $25.00 charge for all returned checks. If you are unable to keep an appointment, please call 24-48 hours in advance to cancel. For appointments that are missed or not cancelled at least 24-48 hours in advance, a fee of $75 will be charged. Any overdue balances due to missed appointments or any other unpaid balances must be paid prior to the next scheduled appointment. After 90 days of an overdue bill, the bill may be sent to a collection agency, if your visits are not covered by your health insurance plan, you will be responsible for the payment. If claims are denied by insurance company, they become the responsibility of the patient

I, ----------, understand that I am responsible for all charges incurred for the treatment provided to me at Gilead Psychiatric Services. I authorize Gilead Psychiatric Services to collect payments from my insurance company for services rendered to me. I understand and agree that regardless of my insurance status, I am ultimately responsible for the payment of any professional services provided to me by Gilead Psychiatric Services. I have read the Financial Policy and agree to the above.

I consent to the payment from my insurance company directly to Gilead Psychiatric services. It is my responsibility to provide accurate insurance information. Any balance remaining after insurance benefits have been paid is my responsibility. I will pay that balance in 60 days unless other arrangements have been made. I understand that in the event of default, the account will be sent to a collection agency. Copays are due at the time of services.

Name _____ Date _____

_____
Signature

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Agreement

Please read each item listed below and sign and date at the end.

I, _____, agree and will comply with the following.

I will take all medications as prescribed.

I understand that controlled Substances will not be filled on the first visit with the provider. The provider needs to verify the accuracy of information provided and determine the necessity of the medication. Continuation of controlled substances from previous providers will be at the discretion of the provider and cannot be demanded.

If I am on a controlled substance through my Psychiatric provider, I will not seek or fill similar controlled medications from another health care provider including Emergency room providers unless authorized by my Psychiatric provider. I understand that there will not be an early refill of a controlled medication.

I will participate in random drug screens as part of my treatment plan if I am on any controlled medications. It may be conducted at least once a year or more frequently at the discretion of the provider. Refusal to participate in drug screens can result in termination of care.

I understand that the use of illicit drugs can result in termination of care.

I understand that it is always my responsibility to safeguard my medications. I understand that lost or damaged medications will not be replaced.

I understand that medications including controlled substances will not be refilled during after hours, holidays or weekends. Refills for controlled substances will be done during visits. I agree to schedule regular follow ups and comply with them to continue refills of all my medications. If a prescription is altered or if I sell or share any medications, I will not be eligible for controlled medications and can result in termination of care. Refill requests must be made 48 hours in advanced during regular business days. Please call the office number at 603-458-6681 for refill requests.

I understand that there is no after hours or weekend coverage and in case of an emergency, I should call 911 or go to the nearest emergency room. Calls received during normal business hours will be returned within 24 hours.

I understand that office staff including the provider should be treated with respect. Disrespectful and threatening behavior can result in termination of care

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I will make prior arrangements with my provider for medication refills while traveling. I may be requested to provide verifiable evidence of where and how long I plan to travel.

I understand that many medications can cause drowsiness or sedation and can cause operation of equipment or driving of vehicles to be dangerous. I agree to refrain from driving or operating machinery under the influence of medications that can cause sedation.

I have read and understand and agree to the above statements.

_____

Patient signature

_____

Print name

_____-

Date

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Authorization to Disclose/Obtain protected Health Information

When you complete this form, you are authorizing the disclosure and /or use of individually identifiable protected health information, as set forth below consistent with state and federal laws concerning the privacy of such information. If you do not provide all the information requested, this authorization may not be valid.

Name ——————————whose Date of Birth is ——-/——/——, Authorize Gilead Psychiatric Services to disclose to and / or obtain the following information from

_____

Name of the Person or Title of Person or Organization

_____

_____

_____

_____

Address/Fax number/Phone number

- -

Description of information to be Disclosed: Client will initial each item to be disclosed

———Psychiatric evaluation
———Medication Information
———School Records
_____Substance abuse evaluation & Treatment
_____Medical history and Physical
_____Discharge Summary
_____Treatment Plan or Summary
_____Diagnosis
_____Medication list

———Medical Information
———Psychological Evaluation
———Toxicology Reports/Drug Screens
———Court Records
_____Progress Notes
_____Diagnostic Evaluation
_____Current Treatment Update

Purpose -This information will be used for sharing information relevant to treatment and coordinate treatment services as needed.
Revocation -I understand that I may revoke this authorization at any time in writing by signing the revocation below.
Expiration - This authorization expires one year from the date signed , unless otherwise specified here.
Conditions
I understand that Gilead Psychiatric services will not base my treatment on whether I give

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authorization for the requested disclosure. However it has been explained to me that failure to sign this authorization could affect ongoing services or treatment being provided.

Forms of Disclosure

Unless specific request is made in writing about how the disclosure should be made, Gilead Psychiatric services reserves the right to disclose information as permitted by the authorization in any manner appropriate and consistent with the applicable law, including but not limited to, verbally, in paper format or electronically.

Re -disclosure

I understand that there is the potential that the protected health information pursuant to this authorization may be disclosed by the recipient and the protected health information will no longer be protected by HIPPA privacy regulations.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is permitted by written authorization of the person to whom it pertains.

I have been given a copy of this authorization for my records.

_____

Signature of Patient / personal representative

_____

Date

_____

For Revocation only

I hereby revoke this authorization to disclose/obtain protected health information on this date

_____

Signature _____

Witness_____

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Notice of privacy practices

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

I am required by law to maintain the privacy of protected health information (PHI) and to provide you a notice of my privacy practices with respect to PHI.

How I may use and disclose health Information about you

- **For Treatment**: I can use your health information and share it with other professionals who are treating you.

- **For Payment/Billing Purposes**: I can use and share your health information to bill and get payment from health plans or other entities.

- **To Comply with the Law**: I will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that I am complying with federal privacy law.

- **Respond to lawsuits and legal actions**: I can share health information about you in response to a court or administrative order, or in response to a subpoena

- **Address workers' compensation, law enforcement, and other government requests**: I can use your PHI for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, for special government functions such as military, national security, and presidential protective services

- **Research Purposes**: I can use or share your information for health research.

- **Help with public health and safety issues**: I can share health information about you for certain situations such as: Preventing disease, helping with product recalls, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, preventing, or reducing a serious threat to anyone's health or safety.

- **Respond to organ and tissue donation requests**: I can share health information about you with organ procurement organizations.

- **Work with a medical examiner or funeral director:** I We can share health information with a coroner, medical examiner, or funeral director when an individual die.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of my responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information I have about you. I will provide a copy or a summary of your health information. You may be charged a reasonable, cost-based fee.

Ask me to amend your medical record

- You can ask me to correct health information about you that you think is incorrect or incomplete. Your request must be made in writing to me at the address listed. I may say "no" to your request but will let you know in writing.

Request confidential communications

- You can ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- All reasonable requests will be accommodated

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. I am not required to agree to your request, and I may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. I will say "yes" unless required by law to share that information.

Get a list of those with whom we've shared information

- You can ask for a list of the times I have shared your health information. I will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked me to make). You will be charged a reasonable, cost-based fee.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting me. You can file a complaint in writing with Lijy Mathew at 59 Stiles Road, Suite 203, Salem, NH, 03079

or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
I will not retaliate against you for filing a complaint.

My Responsibilities

- I am required by law to maintain the privacy and security of your protected health information.
- I will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- I must follow the duties and privacy practices described in this notice and give you a copy of it.
- I will not use or share your information other than as described here unless you tell me that I can in writing. If you decide to change your mind at any time, then let me know in writing.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

I can change the terms of this notice, and the changes will apply to all information I have about you. The new notice will be available upon request, in my office.

If you have any questions regarding this notice or my health information privacy policies, please contact Lijy Mathew, APRN, PMHNP-BC.

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Patient/Client Name: _____

DOB: _____

I hereby acknowledge that I have been presented with a copy of the Gilead Psychiatric Services, PLLC. Notice of Privacy Practices.

Signature of Patient /Personal representative Date

Signature of Staff Member Date

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Telehealth Consent

Telehealth is the use of digital information and telecommunication technologies, such as computers and mobile devices, to access health care services remotely and manage health care. One of the benefits of telehealth is that the patient and clinician can engage in services without being in the same physical location Although there are benefits of telehealth, there are some differences between in-person treatment and telehealth, as well as some risks.

1. I understand that telehealth treatment has potential benefits including, but not limited to, easier access to care.

2. I understand that telehealth has been found to be effective in treating a wide range of disorders, and there are potential benefits including, but not limited to easier access to care. I understand however, there is no guarantee that all treatment of all patients will be effective using this modality.

3. I understand that it is my obligation to notify my Psychiatric Nurse Practitioner of my location at the beginning of each treatment session. If for some reason, I change locations during the session, it is my obligation to notify my Psychiatric Nurse Practitioner of the change in location.

4. I understand that it is my obligation to notify my Psychiatric Nurse Practitioner of any other persons in the location, either on or off camera and who can hear or see the session. I understand that I am responsible to ensure privacy at my location. I will notify my Psychiatric Nurse Practitioner at the beginning of each session and am aware that confidential information may be discussed.

5. I understand that it is my obligation to ensure that any virtual assistant artificial intelligence devices, including but not limited to Alexa or Echo, will be disabled or will not be in the location where information can be heard.

6. I agree that I will not record either through audio or video any of the session, unless I notify my Psychiatric Nurse Practitioner, and this is agreed upon.

7. I understand there are potential risks to using telehealth technology, including but not limited to, interruptions, unauthorized access, and technical difficulties. I understand some of these technological challenges include issues with software, hardware, and internet connection which may result in interruption.

8. I understand that the Psychiatric Nurse Practitioner is not responsible for any technological problems of which he/she has no control over. I further understand that my

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Psychiatric Nurse Practitioner does not guarantee that technology will be available or work as expected.

9. I understand that I am responsible for information security on my device, including but not limited to, computer, tablet, or phone, and in my own location.

10. I understand that my Psychiatric Nurse Practitioner or I (or, if applicable, my guardian or conservator), can discontinue the telehealth consult/visit if it is determined by either me or my Psychiatric Nurse Practitioner that the videoconferencing connections or protections are not adequate for the situation.
11. Doxy.me is the technology service we will use to conduct telehealth videoconferencing appointments. Prior to each session, I will receive an email link to enter the "waiting room" until the session begins. There are no passwords or log in required.

By signing this document, I acknowledge:

1. Doxy.me is not an emergency service. In the event of an emergency, I will use a phone to call 9-1-1 and/or other appropriate emergency contact.

2. I recognize my Psychiatric Nurse Practitioner may need to notify emergency personnel in the event he/she feels there is a safety concern, including but not limited to, a risk to self/others or my Psychiatric Nurse Practitioner is concerned that immediate medical attention is needed.

3. The Doxy.me website facilitates videoconferencing and this technology platform is not, itself, a source of healthcare, medical advice, or care.
4. I understand that the same fee rates apply for telehealth as apply for in-person treatment. It is my obligation to contact my insurer before engaging in telehealth to determine if there are applicable co-pays or fees which I am responsible for. Insurance or other managed care providers may not cover telehealth sessions. I understand that if my insurance, HMO, third-party payor, or other managed care provider do not cover the telehealth sessions, I will be solely responsible for the entire fee of the session.

5. To maintain confidentiality, I will not share my telehealth appointment link or information with anyone not authorized to attend the session.

6. I understand that either I or my Psychiatric Nurse Practitioner can discontinue the telehealth services if those services do not appear to benefit me therapeutically or for other reasons which will be explained to me. I understand there may be no other treatment alternative available.

I have read and understand the information provided above regarding telehealth, and I hereby give informed consent to the use of telehealth.

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_____
Signature of patient (or guardian)

_____
Printed name

_____
Date