Lowcountry Psychiatric Associates

Office (843) 757-4737 Fax (843) 757-4585

Bluffton Office**
25 Clarks Summit Dr. Ste F201
Bluffton, SC 29910

Hilton Head Office
19 Shelter Cove Ln Ste 202
Hilton Head, SC 29928

Joseph Walters, MD
Richard Ford, MD
Leah Carter, NP-BC
Allison Kenney, LISW-CP
Vicki Bonnell, LISW-CP

****Leah, Allison & Vicki only see patients at the Bluffton office****

Patient Intake Form

Name_____DOB_____SSN_____

Cell Phone: _____ Home Phone: _____ Wk Phone: _____

Billing Address_____

City_____ State _____ Zip _____ Email Address _____

Referred by_____ Primary Physician _____

Emergency Contact Info

Name _____ Relationship to Patient: _____

Cell Ph#:_____ Home Ph#:_____

BILLING / INSURANCE INFORMATION: (ONLY for patients of Vicki Bonnell & Allison Kenney)

Insurance Company: _____ Insurance Phone#: _____

Policy/Member ID #:_____ Group Name:_____ Group Number: _____

Subscriber/Policy Holder Name _____ Relationship to Patient_____

Subscriber SSN_____ DOB_____ Cell Ph #:_____

PARENT/GUARANTOR INFORMATION (if patient is under 18 years of age):

Guarantor Name: _____ Relationship to Patient:_____

Guarantor SSN#: _____ Guarantor Phone#: _____

****Patients of Dr. Ford, Dr. Walters & Leah Carter, NP:**

PREFERRED PHARMACY _____ PH# _____

OFFICE POLICIES AND FINANCIAL AGREEMENT

I. PAYMENT ARRANGEMENTS

Therapist services may be totally or partially covered by insurance or some form of managed care. If you plan on providing us with insurance to bill for services, you must arrange to do so **before** we begin the services. Many insurance contracts require authorization of services before the services are provided. Such contracts deny payment for services when pre-authorization has not been obtained. Because there are so many differences among insurance contracts, if you plan to file a claim, we must know the specifics of **your** insurance before we begin providing services. As a courtesy and so that we know what to expect, we generally call to double check your insurance benefits. Please understand that decisions about coverage are made by your insurance company. Your insurance company can help you to understand the procedures for obtaining coverage. It is your responsibility to work this out with your insurance company.

Services provided to you by **Richard Ford, M.D**., **Joseph Walters, M.D**. and **Leah Carter, NP** are private fee for services. **They do not participate in any insurance panels**. Elimination of insurance obligations has allowed these two providers to provide high-quality services that are tailored to your personal needs, not insurance company demands. Therefore, you will need to pay out-of-pocket at the time services are rendered, and obtain reimbursement from your insurance companies for out-of-network benefits (except for Medicare). Payment is due in full at the time of service and payments need to be made payable to your physician.

Please note the following if you are a patient of Dr. Ford, Dr. Walters or Leah Carter:

a. They are not Medicare providers and do not participate with any insurance.
b. Provider & patient agree and understand claims **cannot be filed to Medicare.**
c. Fees for service are mutually agreed upon, based upon those listed under "Fees for Service".
d. This agreement remains in force for as long as you are provided care in our office.

1. FEE FOR SERVICE (Patients of Dr. Walters, Dr. Ford and Leah Carter or patients without insurance)

***** WE DO NOT OFFER PAYMENT PLANS*****

*****Charges are subject to change**** **Payments for services are due at the time service is rendered.**

Time in excess of standard sessions is prorated. Fees for special services (e.g., forensic services, attorney/legal services, letter preparation/records, prior authorization for medical/pharmacy insurance, and/or any other forms/paperwork) need to be arranged separately and will be charged at the fee determined by the provider's discrepancy. Fees for testing vary by the type of assessment needed. If additional time or services (e.g., telephone calls lasting more than scheduled appt, reports, treatment plans, or letters) are provided, a prorated fee will be charged. When requesting any service, it is best to inquire what the charge will be. In the event that any provider in this office is personally subpoenaed to testify in any proceeding, or at any deposition, or requested to produce any files, documents and/or records by any party, any attorney, or any Court in any matter relating to you, you agree to pay for the professional time and expenses of the provider, administrative staff, as well as any attorney fees and costs.

2. INSURANCE- Patients of Dr. Ford, Dr. Walters, & Leah Carter

If you have insurance coverage and wish to use it, you should contact your insurance representative to obtain forms and coverage information. The insurance contract is between you and the insurance company. **You are responsible for all payments directly to your physician and the insurance company may reimburse you directly (except for Medicare).** We will provide a statement for you to file your claims to your insurance (except for Medicare), upon your request.

3. INSURANCE (Out of Network Providers) - Patients of Vicki Bonnell & Allison Kenny

If you have insurance but we are not a participating provider in your insurance plan.

If you have insurance coverage and wish to use it and the provider you are seeing is not in network, we will give you an itemized bill for you to file claims to your insurance however you will be responsible for the full amount of the charges unless a flat fee agreement for sessions has been approved by the provider.

4. INSURANCE (In Network Providers) – Patients of Vicki Bonnell & Allison Kenney

Fees are reimbursed at the Usual and Customary rate allowed by our contract with your insurance company. Provided that services have been properly pre-authorized, you are responsible for any co-pay/deductible/coinsurance which you are expected to pay at the time of service. Often, the amount is a percentage of the contracted fee. This percentage may change as determined by your insurance. If your deductible has not yet been satisfied, you will need to pay the full fee for each session until it is. We will bill your insurance company for their portion of the fee.Some services may not be covered under the mental health benefit of your insurance contract. Those services which you have requested, and which are not covered benefits, will be billed directly to you.

***PSYCHOLOGICAL TESTING IS NOT COVERED BY INSURANCE**

II. POLICY ON MISSED/LATE APPOINTMENTS

You will be charged for all time reserved for you. With sufficient notice, an appointment can generally be rescheduled. Failure to give at least 24-hours notice of cancellation will result in a charge at the regular fee. Since insurance and managed care companies do not pay for missed sessions, you will be required to cover the full fee, even if you ordinarily only pay the co-pay/deductible.

III. CONFIDENTIALITY

The patient/provider relationship is privileged and is protected by the law and ethical standards. Ordinarily, no information can be released without your specific written approval. Certain legal circumstances can arise whereby written documents can be subpoenaed. In addition, we are mandated to report to Protective Services whenever there is reason to suspect abuse of a child in the care of an adult and abuse of a disabled person. Be sure to discuss any questions with your clinician. Note that when you sign the Consent & Authorization Release Form, you are authorizing LPA to release information as noted.

Insurance companies generally require diagnostic/treatment information before they will agree to pay benefits. We will release that information to them with your permission, as indicated on the Consent & Authorization Release Form. We will discuss with you the diagnosis and any other information your insurance company requests. While this information is very sensitive and is generally treated as such by insurance carriers, we cannot guarantee that your confidentiality will be respected by any particular insurance carrier or employer of such insurance carrier. If you prefer that we do not release information to your insurance carrier for reimbursement purposes, you will remain responsible for the fee for services.

IV. MEDICATION REFILLS

Whenever possible, prescription refill requests should be handled during your visit with your physician. Your provider will prescribe enough medication to last until the next recommended appointment. Prescription for controlled substances will only be provided during appointments. While being prescribed a controlled substance, you will need to be seen monthly for the first few months or as directed by your provider and then at least every 3 months once stable, without exception. If a prescription refill is necessary outside of a normal office visit, please contact your pharmacy and they will fax over a refill request to your provider. (Please note that your physician may require you to make an appointment prior to getting any refills.) Please allow a minimum of 72 business hours for all medication refill requests. No prescription refill requests will be completed after normal office hours or on weekends. We encourage you to request refills, a few days in advance when you will need them and to anticipate your need for refills before weekends and holidays. **There will be a $25 charge for same day refill requests, requests less than 72 hour notice, and/or refills given outside of business hours.**

V. PHONE CALLS/PHONE CONSULTATIONS

We typically return routine/non-urgent phone calls within the same business day if the message is left within normal business hours. Our policy is to provide quality patient care through scheduled office visits and you may be directed to schedule an appointment. If your provider is not in the office you will receive a phone call when your provider returns and/or when the staff receives a response from the provider.

VI. AFTER HOUR PHONE CALLS

If you have an urgent matter that cannot wait until regular business hours to call the office, you may call our after-hours phone number 866-256-4501 to contact a provider, however, charges may apply for after-hours phone service.

VII. PHONE/SKYPE/FACETIME APPOINTMENTS

These may be substituted for office appointments in the event you cannot be seen in person and will be charged at the same rate as an in-office appt. **Disclosure:** Information transmitted over a website, Skype, email, or phone may not be secure.

VIII. EMERGENCIES

In the event of an emergency, please go to the nearest emergency room or call 911 immediately.

My signature below indicates that I have read and understand the office policies and financial agreement.

_____ _____

Signature Date

LOWCOUNTRY PSYCHIATRIC ASSOCIATES Name: _____
NEW PATIENT HISTORY

Current Symptoms/Problem Checklist: Please check any symptoms….

( ) Depression	( ) Racing thoughts	( ) Excessive worry	( ) Substance Abuse
( ) Unable to enjoy activities	( ) Impulsivity	( ) Anxiety/Panic	( ) Family Issues
( ) Sleep disturbance	( ) Increase risky behavior	( ) Avoidance	( ) Legal Issues
( ) Loss of interest	( ) Increased/decreased libido	( ) Hallucinations	( ) Loss/Bereavement
( ) Concentration/Memory	( ) Decrease need for sleep	( ) Suspiciousness	( ) Pain Issues
( ) Change in appetite	( ) Excessive energy	( ) Excessive guilt	
( ) Increased irritability	( ) Fatigue	( ) Crying spells	

OTHER:_____

Suicide Risk
Have you ever tried to harm yourself in the past? ( ) Yes ( ) No.
Have you had any recent thoughts, or do you currently have any thoughts of suicide? ( ) Yes ( ) No.

Medical History: Allergies_____ Current Weight _____ Height _____

List ALL current medications and how often you take them/dosage:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Current over-the-counter medications or supplements:_____

Current/Past major medical problems (chronic illness, surgeries, hospitalizations…)
_____
_____
_____

For women:
Date of last menstrual period: _____Are you currently, or do you think you are pregnant?( )Yes( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Family History (Medical/Psychiatric Diagnoses, Substance Abuse or Self-Injury/Suicide):

_____

_____

Past Psychiatric History
Outpatient treatment ( ) Yes ( ) No. If yes, Please describe when, by whom, and nature of treatment.
_____

_____

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
_____

Past Psychiatric Medications: If you have ever taken any of the following medications (please circle).
Mood/Thoughts: Prozac, Zoloft, Luvox, Paxil, Celexa, Lexapro, Viibryd, Effexor, Cymbalta,Wellbutrin, Remeron, Serzone, Anafranil, Pamelor,Tofranil, Elavil, Tegretol, Lithium, Lamictal, Tegretol, Topamax, Seroquel, Zyprexa, Geodon, Abilify, Clozaril, Haldol, Prolixin, Pristiq, Brintellix, Fetzima, Savella
Sleep: Ambien, Lunesta, Sonata, Rozerem, Restoril, Desyrel/Trazodone
ADHD: Adderall, Concerta, Ritalin, Vyvanse, Focalin, Dexedrine, Strattera
Anxiety: Xanax, Ativan, Klonopin, Valium, Restoril, Librium,Tranxene, Buspar, Vistaril, Benadryl, Propranolol
Other: _____

Any negative/positive experiences with these medications? _____

Substance Use:
Do you (or others) think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances and when/where were you treated? _____
Days/wk drinking alcohol: _____ Avg. Number drinks/day: _____ Most drinks/day: _____
Do you have current/past problems with the use/abuse of illegal substances? If so, which substances?
_____
Have you abused prescription medication? If so, which medications? _____
How many caffeinated beverages do you drink a day**?** Coffee _____ Sodas _____ Tea _____
Tobacco History: active_____ past_____

Family Background and Childhood History:
Where were you born_____ where did you grow up _____
Were you adopted? ( ) Yes ( ) No
Did your parents' divorce? ( ) Yes ( ) No Your age at their divorce:_____ you lived with_____
List your siblings and their ages: Sisters (ages)_____
Brothers (ages)_____

Educational History: What is your highest educational level or degree attained? _____

Spiritual life: Do you belong to a particular religion or spiritual group? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Occupational History:
Are you currently: ( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired
What is/was your occupation?_____
Have you ever served in the military? _____ If so, what branch and when? _____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed
How long? _____ Total number of marriages?_____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____
Do you have children? ( ) Yes ( ) No. If yes, list ages and gender_____

Legal: Have you ever been arrested? _____ Do you have any pending legal problems?_____

****THIS FORM MUST BE COMPLETED BY ALL PATIENTS****

CREDIT CARD AUTHORIZATION FORM

Lowcountry Psychiatric Associates
25 Clarks Summit Drive Suite F-201
Bluffton, SC 29910
Office (843) 757 4737 Fax (843) 757 4585

Joseph Walters, M.D., Richard Ford, M.D., Leah Carter, NP-BC, Vicki Bonnell, LISW-CP, Allison Kenney LISW-CP

Please indicate the form of payment you wish to use for any services rendered through this practice. The following forms of payment are accepted: VISA, MASTERCARD, DISCOVER and AMEX. Service fees will be deducted from the designated account at the time services are rendered for office visits, co-pays, deductibles, no show/missed appts or less than 24 hours notice for a canceled appointment.

PATIENT INFORMATION:

PATIENT NAME_____ DATE OF BIRTH_____

CARDHOLDER INFORMATION:

☐ (Patient) *Same as above* OR ☐ Other (relationship to patient)_____

NAME_____ PHONE #:_____

I authorize Lowcountry Psychiatric Associates, LLC to keep my credit card on file and charge/deduct for any service fees (listed above) from the credit or debit card ending in _____.
(**last four digits of card**)

CREDIT/DEBIT CARD INFORMATION

Please provide your payment information below:

CARD TYPE (circle one): **VISA** **MasterCard** **Discover** **American Express**

CARD #:_____ EXP DATE:_____/_____ CVV:_____

_____ _____
Cardholder Signature **Date**

Lowcountry Psychiatric Associates, LLC
Office: (843) 757-4737

UNDERSTANDING CHARGES FOR CANCELLED/MISSED APPOINTMENTS

Appointments are made according to your provider's availability and at times that are convenient to you. If for any reason you need to cancel your appointment, you must call at least 24 business hours in advance. If you cannot attend your session and need to cancel in less than 24 hours, you will be required to pay out-of-pocket for your missed appointment. Please note that neither insurance companies, nor Medicare pay for missed appointments. The charge will be the full charge of the scheduled appointment.

Given that the office is closed on Fridays, all Monday appointments that are cancelled between Thursday at 4:00 pm until 8:30 am on Monday will be charged in full. If you leave a message, the time of your cancellation will be determined by the date and time indicated on the voice-mail.

Your provider understands that there are situations beyond your control and you may believe that you should not be charged for appointments not cancelled on time due to such situations. However, please understand that the provider's own financial obligations are not lessened when he/she misses an hour of work because they were not given sufficient time to fill the appointment; it should not be expected of the provider to assume the loss of such unforeseeable circumstances. You may have one such situation during the course of many months whereas, given the number of clients that he/she sees in a week, they may be faced with many such hours in a single month with the resulting loss of income. Consequently, you will be responsible for any appointment that was not cancelled within the 24 hours minimum requirement, whatever the reason for missing the appointment.

Patient/Guardian signature:

_____ Date: _____

By my signature above, I hereby acknowledge I am aware of and fully understand the conditions and office policy of payments for missed appointments.