NEW PATIENT REGISTRATION FORM

Today's Date:			Lilac Center Location: ☐Pennsylvania Ave. ☐Holmes St. ☐Foxridge Dr.		
PATIENT INFORMATION					
Patient's last name:	First:	Middle:	Marital status:		
Address:			D.O.B:	Age:	Sex:
City:	State:		Zip:		
Home phone:	Work phone:		Cell phone:		
Employer:	Your Occupation:		Employer phone:		
Employer Address:					
City:	State:		Zip:		
Referred by: ☐ Hospital/Clinic - Name:		☐ Physician - Name:		☐ Web Search ☐ Advertisement/Brochure	
Other family members seen here? ☐Yes ☐No If Yes, name					
PRIMARY INSURANCE INFORMATION (IF APPLICABLE)					
(Please give your insurance cards to the receptionist)					
Insured's Name:	D.O.B:	Relationship:	Phone:		
Insurance company:					
Group number:	Insured ID:	Co-payment:			
Employer's Name	Employer's phone:				
Address:					
City:	State:	Zip:			
SECONDARY INSURANCE INFORMATION (IF APPLICABLE)					
Insured's Name:	D.O.B:	Relationship:	Phone:		
Insurance company:					
Group number:	Insured ID:	Co-payment:			
Employer's Name	Employer's phone:				
Address:					
City:	State:	Zip:			
COORDINATION OF CARE					
It is important for your healthcare providers to to work together in coordinating your care. Please complete information below and indicate your approval.					
Primary Care Physician:			Phone:		
Address:	City:	State:	Zip:		
May we contact your Physician? ☐Yes ☐No ☐I don't have a Physician					
Psychiatrist/Therapist:			Phone:		
Address:	City:	State:	Zip:		
May we contact your Psychiatrist/Therapist? ☐Yes ☐No ☐I don't have a Psychiatrist/Therapist					
IN CASE OF EMERGENCY					
Emergency Contact Name:			Relationship:		
Address:	City:	State:	Zip:		
Home phone:	Work phone:		Cell phone:		
The above information is true to the best of my knowledge. I authorize you to release any information required to process my claims. I understand that I am financially responsible for any balance not paid by insurance. I have received a copy of the **Provider and Patient Services Agreement** and agree to its terms.					
Signature:			Date:		

COORDINATION OF CARE REQUEST

Client Name: _____

Client DOB: _____

Dear _____

I am writing to let you know that I saw your client named above for a mental health assessment on:

_____

The Client reported symptoms that I believe are consistent with the diagnosis of:

_____

I have recommended the following:

- ❑ On-going therapy to reduce symptoms of mental health diagnosis
- ❑ Medication management
- ❑ Substance abuse treatment
- ❑ Eating disorder treatment
- ❑ Chronic illness, mindfulness and exposure for management and pain reduction
- ❑ Routine care to improve quality of life and connection in relationships
- ❑ Dialectical Behavioral Therapy to reduce personality disorder symptoms

We are not requesting client medical records at this time. We are only informing you we are working with the client and wish to coordinate care with you.

This client has signed an authorization form, allowing us to exchange pertinent information with you. If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

Respectfully,

Receive a book explaining our therapy approach FREE by calling 816-221-0305

Lilac Center

Quality Hill
1029 Pennsylvania Ave.
Kansas City, MO 64105

Hospital Hill
2546 Holmes St.
Kansas City, MO 64108

Mission, KS
5300 Foxridge Dr.
Mission, KS 66202

816-221-0305 • www.lilaccenter.org

rev. 02-15-16

Authorization to Release Information

Lilac Center

Client name.....

Date of birth.....

I authorize Lilac Center to:

Provide records to:	**Receive records from:**	
.....	.....	Primary Care Physician: .....
.....	.....	Psychiatrist: .....
.....	.....	School Counselor: .....
.....	.....	Emergency Contact: .....
.....	.....	Other: .....

The following requested items to be disclosed/obtained (initial items)

.....Any and all information
.....Written and verbal information
.....Summary of care and services
.....Evaluations and assessments
.....Confirmation of participation/attendance
.....Other.....
.....Progress notes
.....Medical records
.....Pharmacy records
.....Dates and types of services provided

The purpose for this disclosure is (initial items)

.....Client care and treatment
.....Attorney or court request
.....Mangaged care and Insurance
.....Other.....

I understand that this authorization shall remain valid from the date of my signature below for 12 months thereafter and ending on.....

I have been infommed that I may revoke authorization by written or oral communication to the Lilac Center.
I certify this form has been fully explained to me and I understand its contents.

.....
Signature of Client Date of Authorization

.....
Signature of Witness Date

PROVIDER & PATIENT SERVICES AGREEMENT

Welcome to Lilac Center

This document contains important information about our practice and its business policies. Although these documents are long and sometimes complex, it is very important that you read them carefully. We can address any questions you have about the procedures before your next session. When you sign this document, it represents an agreement between you and Lilac Center. You may revoke this agreement in writing at any time. That revocation will be binding except for information already disclosed; obligations imposed on us by your health insurer in order to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

OUR SERVICES

Our main approach to treatment is called Dialectical Behavior Therapy (DBT). DBT is a collaborative process where we work with you to help you learn skills for changing certain problematic behaviors and emotions. This process is most successful when we are able to develop an open and trusting professional relationship. You will most likely achieve your goals if you attend appointments and work hard between meetings to practice the skills we teach. Therapy often leads to better relationships, solutions to specific problems, and a significant reduction in the feelings of distress. Treatment usually includes individual sessions of 50 minutes each and can include weekly group therapy and phone coaching and crisis intervention. If you have any questions about the nature of the treatment, please don't hesitate to ask.

INITIAL ASSESSMENT

Your initial session(s) will involve an evaluation of your needs. By the end of the evaluation, we will be able to offer you some first impressions of what your work will include and a plan to follow, if you decide to continue with our services. You should evaluate this information along with your own opinions of whether you feel comfortable working with us. Treatment/consultation involves a commitment of time, money, and energy, so you should be careful about the clinic or provider you select. If you have questions about procedures, they should be discussed with us whenever they arise. If your doubts persist, we will be happy to help you set up a meeting with another mental health professional for a second opinion.

PROFESSIONAL FEES

You are responsible to pay for your treatment. We will help you file the claim with your health insurance provider, but if your insurance company does not pay for any reason you are responsible to pay.

Clinical Fees:

Initial evaluation (45-55 min.)	$165.00
Individual psychotherapy (45-55 min.)	$145.00
Family or couples psychotherapy (45-55 min.)	$145.00
Group psychotherapy (90-120 min.)	$120.00
Initial psychiatric assessment	$250.00
Follow-up medication management with psychiatrist	$150.00
No-show or late cancellation fee	$40.00

Other Fees:

Non-clinical documentation fees such as preparing letters, forms for schools, employers or court proceedings.	$25.00
Consultation fees for presenting educational programs, providing testimony in court, or providing extensive education or support for families of clients.	$120.00 per hour

Fees for Private Pay and out-of-pocket with no insurance billing:

Insurance or third-party payers are typically billed for your service within the week you were seen. Some insurance companies require pre-authorization; we will work closely with you and your insurance provider to assure you receive your coverage benefits. If we accept your insurance we accept their rate of coverage.

You will be expected to pay for each session at the time it is held, unless another schedule is agreed upon or unless you have insurance coverage. **If we file your insurance, you are expected to make your co-payment at each visit.** We accept cash, personal checks, Visa, and MasterCard. There will be a $35 service charge for returned checks. **If overdue balance accrues to more than $300, we reserve the right to suspend services until payments are made to reduce the balance owed.**

If your account has not been paid for more than 60 days and you have not made arrangements for payment, we have the option of using legal means to secure the payment. This may include collection agency or small claims court which will require disclosing otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

NO-SHOW AND CANCELLATIONS
When an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hours advance notice of cancellation. **If you cancel with less than 24-hour notice you will be charged a $40 no-show fee.** It is important to note that insurance companies do not provide reimbursement for cancelled sessions. Repeated missed appointments may necessitate termination of treatment.

INSURANCE REIMBURSEMENT
In order for you to set realistic treatment goals and priorities, it is important to evaluate what resources you have available to pay for your treatment. If you have a health insurance policy, it will usually provide some coverage for mental health treatment. We will fill out required forms and provide you with assistance in receiving the benefits to which you are entitled; however, you (*not your insurance company*) are responsible for full payment of your bill. It is very important that you find out exactly what mental health services your insurance policy covers.

You should carefully read the section in your insurance coverage booklet that describes mental health services. If you have questions about the coverage, call your plan administrator. Our office will provide you with any information we have based on our experience and will be happy to help you in understanding the information you receive from your insurance company. If your failure to comply with your insurance company's requirements regarding choice of providers, authorizations, or other issues results in the denial of claims, you will be responsible for paying in full. If your coverage changes, it is your responsibility to notify the office and to comply with your new policy.

You should also be aware that your contract with your health insurance company requires that we provide a clinical diagnosis and information about the services provided to you. Sometimes we must provide additional clinical information such as treatment plans or summaries, or copies of your entire clinical record. In such situations, every effort will be made to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. Though all insurance companies claim to keep such information confidential, we have no control over what they do with it once it is in their hands. In some cases, they may share the information with a national medical information databank. By signing the appropriate section of this Agreement, you agree to the provision of requested information to your carrier.

Once we have all of the information about your insurance coverage, we will discuss what you can expect to accomplish with the benefits that are available and what will happen if they run out before you feel ready to end your sessions. You have the right to pay for services yourself to avoid the problems described above.

HIPPA GUIDELINES

Health Insurance Portability and Accountability Act (HIPAA), is a federal law designed to protect your privacy and your rights with regard to the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and health care operations. HIPAA requires that we provide you with the *Notice of Privacy Practices* that explains HIPAA and how it affects you. The law also requires that we obtain your signature acknowledging that you have received this information.

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a provider. Several types of communications and the consent they require are discussed below.

1) Generally, information about your treatment can be released to others only if you sign a written Authorization Form that meets certain legal requirements imposed by HIPAA.

2) There are other situations, however, that require only that you provide written, advance consent. Your signature on this Agreement provides consent for the following:

• We may occasionally consult other health and mental health professionals about a case. During a consultation, every effort is made to avoid revealing your identity. The other professionals are also legally bound to keep the information confidential. You will not be told about these consultations unless your provider feels that it is important to your work together.

• We practice with other mental health professionals and employ administrative staff. In many cases, some protected information may be shared with these individuals for both clinical and administrative purposes, such as scheduling, billing and quality assurance. All of the mental health professionals are bound by the same rules of confidentiality. All staff members have been given training about protecting your privacy and have agreed not to release any information outside of the practice without the permission of a professional staff member.

• We have contracts with other vendors such as software billing providers and electronic records providers, collections agencies, legal and accounting services. As required by HIPAA, we have a formal business associate contract with these other businesses, in which they promise to maintain the confidentiality of this data except as specifically allowed in the contract or otherwise required by law. If you wish, we can provide you with the names of these organizations and/or a blank copy of this contract.

• If providers believe that a patient presents an imminent danger to his/her health or safety, they may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

• If you are involved in a court proceeding and a request is made for information concerning the professional services that are provided to you, such information is protected by the provider-patient privilege law. Information cannot be provided without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information.

• If a patient files a complaint or lawsuit against a provider, that provider may disclose relevant information regarding that patient in order to defend myself.

• If a patient files a worker's compensation claim, and services are being compensated through workers compensation benefits, a provider must, upon appropriate request, provide a copy of the patient's record to the patient's employer.

In addition, there are some situations in which we are legally obligated to take actions, which are necessary to attempt to protect others from harm and which may require revealing some information about a patient's treatment. They include the following:

• If there is cause to suspect that a child under 18 is abused or neglected, or reasonable cause to believe that a disabled adult is in need of protective services, the law requires that a report be filed with the Department of Children and Family Services. Once such a report is filed, additional information may be required.

• If there is reason to believe that a patient presents an imminent danger to the health and safety of another, we may be required to disclose information in order to take protective actions, including initiating hospitalization, warning the potential victim, if identifiable, and/or calling the police.

If such a situation arises, your provider will make every effort to fully discuss it with you before taking any action and will limit disclosure to only what is necessary.

While this written summary of exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that any questions or concerns that you may have now or in the future be discussed. The laws governing confidentiality can be quite complex. In situations where specific advice is required, formal legal advice may be needed.

PROFESSIONAL RECORDS

You should be aware that, pursuant to HIPAA, we may keep Protected Health Information about you in two sets of professional records. One set constitutes your Clinical Record. It includes information about your reasons for seeking therapy, a description of the ways in which your problem impacts on your life, your diagnosis, the goals that are set for treatment, your progress towards those goals, your medical and social history, your treatment history, any past treatment records received from other providers, reports of any professional consultations, your billing records, and any reports that have been sent to anyone, including reports to your insurance carrier. Except in unusual circumstances that involve danger to yourself and/or others or the record makes reference to another person (unless such other person is a health care provider) and your provider believes that access is reasonably likely to cause substantial harm to such other person, you may examine and/or receive a copy of your Clinical Record, if you request it in writing. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. For this reason, it is recommended that you initially review them with your provider, or have them forwarded to another mental health professional so you can discuss the contents. (There normally will be a charge for copying records). The exceptions to this policy are contained in the attached Notice Form. If your request for access to your records is refused, you have a right of review, which will be discussed with you upon request.

In addition, your provider may also keep a set of Psychotherapy Notes. These notes are for your provider's use and are designed to assist in providing you with the best treatment. While the contents of Psychotherapy Notes vary from client to client, they can include the contents of your conversations with your provider, an analysis of those conversations, and how they impact on your therapy. They may also contain particularly sensitive information that you may reveal to your provider that is not

required to be included in your Clinical Record and information revealed to your provider confidentially by others. These Psychotherapy Notes are kept separate from your Clinical Record. Your Psychotherapy Notes are not available to you and cannot be sent to anyone else, including insurance companies without a separate signed Authorization.

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Records and disclosures of protected health information. These rights include requesting that your provider amend your record; requesting restrictions on what information from your Clinical Records is disclosed to others; requesting an accounting of most disclosures of protected health information that you have neither consented to nor authorized; determining the location to which protected information disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to view and copy your records,. Your provider will be happy to discuss any of these rights with you.

MINORS & PARENTS

Children of any age have the right to independently consent to and receive mental health treatment without parental consent. Information about that treatment cannot be disclosed to anyone without the child's agreement. While privacy in psychotherapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents.

It is our policy not to provide treatment to a child under 12 unless he/she agrees that I can share whatever information I consider necessary with his/her parents.

For children 13 and over, we request an agreement between my patient and his/her parents allowing me to share general information about the progress of the child's treatment and his/her attendance at scheduled sessions. We will also upon request provide parents with a summary of their child's treatment when it is complete. Any other communication will require the child's Authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.

CONTACTING US

Routine, Non-emergency Situations:

Our office staff is available from 8:00 am to 7:00 pm Mon-Thurs. Our office phone number is 816-221-0305. You can also email us at support@lilaccenter.org Providers are normally not available by telephone during these hours because of client appointments. You will be able to leave them a voicemail during business hours. We check our voice mail between sessions and make every effort to return your call on the same day you make it, with the exception of weekends and holidays. If you are difficult to reach, please leave information about times when you will be available.

Emergency/Crisis Situations:

If you experience an emergency or crisis situation, please call your providers cell phone (provided on their business card or by them directly). They will call you back as soon as possible. Should you feel you cannot wait for a return call, you should call your physician or psychiatrist or go to the nearest emergency room. If your provider will be unavailable for an extended time, you will be provided with the name of a colleague to contact, if necessary.

Medical Emergencies:

In case of a medical emergency, the patient should be taken to the nearest emergency room or call 911 for assistance. Should the emergency occur in our office, 911 will be called.

Clients Name: _____

Your Co-Payment is: _____

Your Deductable is: _____

Your Policy Limits are: _____

Your Balance Due is: _____

Co-Payments are due at time of service:
You are required to check-in with office staff and pay your co-payment before your appointment.

Late Cancellation or Missed Appointments:
Please give 24 hour notice. If you were unable to give notice, you must pay your missed appointment fee of $40 prior to your next appointment.

Overdue Accounts:
We reserve the right to suspend services for accounts with overdue amounts of $300 or more. Please make payment arrangements with the office manager.

Collections Policy:
If your account has not been paid for more than 60 days and you have not made arrangements for payment, we have the option of using legal means to secure the payment. This may include collection agency or small claims court which will require disclosing otherwise confidential information. In most collection situations, the only information released regarding a patient's treatment is his/her name, the nature of services provided, and the amount due. If such legal action is necessary, its costs will be included in the claim.

YOUR SIGNATURE INDICATES YOU HAVE READ AND BEEN GIVEN THE PROVIDER & PATIENT SERVICES AGREEMENT AND AGREE TO ITS TERMS. IT ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM.

_____

Client Name (legible print please)

_____

Client Signature Date

_____

Social Security Number

_____

Your Address

_____

Phone Number

_____

Email Address

_____

The name of the person responsible for payment (if not client)

_____

That person's phone number

_____

That person's address

(rev. 2-11-16)