Barrier Islands Psychiatry 1616 & 1620 Ashley River Road Charleston SC 29407 843-556-8177

Barrier Islands
ADDICTION MEDICINE PSYCHIATRY

Patient Registration

As it appears on your insurance card: **Today's Date:_____**

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____

Preferred Name: _____

Address: _____

City, State, Zip: _____

Email: _____

Preferred Contact Number: _____
Secondary Contact Number: _____

Emergency Contact:

Name: _____ Number: _____
Relationship to the patient: _____

***Preferred Pharmacy Name and Number**: _____

Who may we thank for your referral? _____

Please provide a current copy of your insurance card. If the insurance policy holder is someone other than the patient, please list their name and date of birth:

_____

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Office Policies and Procedures

Please **initial each section** after reading. Understanding the way our office works will help you communicate with us in a way that will best meet your needs.

Prescriptions and Refills

All **prescriptions should be requested during appointments** when your medical record is available to the doctor. Follow up appointments are scheduled to ensure that you do not run out of medications between appointments. If you are low on medication for any reason, please contact us at least several business days before running out rather than waiting until the last moment.

If you require a **phoned in prescription or prescription written outside of an appointment**, a **$25 fee** will be required.

Please note, Federal and State laws prohibit the dispensing of certain medications without examination.

Refill requests faxed or called into our office by your pharmacy will **not** be honored.

If you have missed or cancelled an appointment, you are responsible to reschedule your appointment in a timely fashion to ensure proper treatment and medication management. Consistent follow up appointments are necessary for safe medical care.

I agree not to sell, share, or give any of my medications to another person.

____ INITIALS

Lost/Stolen Medications

Medications are the sole responsibility of the patient and may not be replaced if lost or stolen. Always fill out a police report for lost or stolen medications. There is a **$25 fee** for all **prescriptions written or called in outside of appointment times.**

In general, it is the pharmacy's discretion whether to refill a lost prescription early. The doctor may call on your behalf to request this, but whether the doctor does this will depend on several factors. If the medication you lost is a controlled substance, the pharmacy will most likely NOT be able to fill the prescription early. Our office is NOT responsible for replacing medications early and is held by strict local and federal laws that we must comply with or face penalties.

If you are being prescribed a controlled medication by the doctor, it is expected that you abide by the following rules:

1. **Just use one doctor**. It is illegal to get controlled prescriptions from more than one provider.
2. If the doctor has any reason at all to suspect that you are abusing, selling, giving away, sharing or otherwise acting irresponsibly with your medications, you may no longer be prescribed your medication and also may be discharged from the practice.
3. **Keep your medications in a safe and well controlled environment.** (Away from access by children, pets, and visitors or in an unwise location such as above the toilet or sink.) It would be preferable if the medications were kept locked up.
4. **Police reports are required for lost or stolen medications**. (An actual report or a current case number.)
5. **Compliance with toxicology testing (urine or saliva screens) and/or medication counts.**

6. Be aware that your prescriptions can be monitored through a Prescription Reporting System, which also includes information from nearby states.

____ INITIALS

Appointments

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. If you are unable to keep your appointment, please give at least 24 business hours notice to avoid a fee. Excessive abuse of scheduled appointments may result in being discharged from the practice. If you are more than 10 minutes late to your appointment, you will be rescheduled.

Doctor visits carry a $75 no show fee and a $75 same day cancellation fee. **Therapy appointments carry a $125 fee for no show or same day cancellation** due to the length of the reserved time. Established therapy patients may use the reserved time as a phone session, but it will still carry the $125 charge as insurance may not cover phone appointments.

Patients are seen by appointment and our office makes every effort to provide courtesy reminder calls; however **it is your responsibility to keep all scheduled appointments**.

Please note there may be difficulty rescheduling you when we are provided short notice if your provider is booked out. We do try to keep a cancellation list to offer sooner appointments, however this is provided as a courtesy on a first come, first served basis and does not guarantee earlier visits.

_____ INITIALS

Children and Pet Policy

We love children and pets, but please only bring pictures. In our efforts to offer a relaxing and professional atmosphere where you can focus on your treatment, we ask that you refrain from bringing your guests (not involved in treatment), children, and pets to the office. Our practice caters to adult care and is not appropriate for children. We are unable to provide childcare while you are being treated.

_____ INITIALS

Emergencies

If you feel you need urgent medical care please call 911, go to the nearest hospital emergency room, or call Palmetto Lowcountry Behavioral Health (PLBH) at 843-747-5830. A doctor's referral is not needed for admission to PLBH. Barrier Islands Psychiatry after hours' number is 843-414-9670. After hours calls may carry a fee.

_____ INITIALS

Telephone Policy

Office Phone Calls

We take pride in answering your call in person whenever possible. However, there are times when heavy call volume or patient load may prevent us from speaking with you directly. If you get a recording, you will obtain best results by observing the following directions:

- Plan ahead and call once. Multiple calls add more delay in returning your call.
- Keep your message brief.
- Allow 24-48 business hours for a return call, especially if you call late in the day.
- Office Staff will be polite and respectful. They deserve the same in return.

- Abusive or threatening calls will be reported.

____INITIALS

Clinical Phone Calls/Patient Portal

We encourage you to call with questions regarding your medical care. To uphold quality of care and fairness to all, providers **cannot** take time from patient appointments to accept or return patient phone calls. **Medical Assistants** are available to speak with you about questions and/or concerns which will then be presented to your provider for review. This is the **fastest and most efficient way to communicate with your provider outside of appointments**.

If you still feel that you must speak directly with your provider, we will make every effort to get you an earlier appointment.

If you are enrolled in our patient portal please note that it is only monitored/responded to during normal business hours.

____ INITIALS

Payment Policy

Health care regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud. **Payment is due in full at the time of service**. We accept cash, checks, VISA, MasterCard, Discover and American Express. You may also pay your bill online or through the patient portal. You will be required to keep your account current in order to schedule more services with our office.

Please remember that the **responsibility for the payment of medical bills rests with you, the patient**. We will gladly file with your insurance company, but cannot influence their policies regarding the extent or amount of payment. Your insurance policy is a contract between you and your insurance company. You are responsible for knowing what your insurance covers, your current copay and the providers/network covered under your health insurance plan. Any service provided but not covered by insurance will be your responsibility to pay.

In the event of financial hardship, please contact our office in advance to make payment arrangements. In most cases, we can arrange scheduled payment plans or refer you to a facility that offers a sliding scale.

We reserve the right to use additional billing or collection agencies for delinquent accounts.

____ INITIALS

Letters and Forms

Any forms or reports that must be completed by your provider as requested by you or a third party are subject to a charge. You can have the form filled out during the office visit or drop off the paperwork. **Please be considerate and allow 14 business days for letters and forms to be completed.** To expedite the filling out of the form, you should complete parts of the form that you can fill in like your name, address, etc.

____ INITIALS

Waiting Room Courtesy

- Please check in with the receptionist or sign in upon your arrival.
- Patient comfort and privacy is of utmost importance to us. Please do not disturb others who are waiting.
- Please refrain from talking on your cell phone.
- Limit messy food and drink.
- Avoid wearing heavy perfumes or oils in consideration of patients or staff with chemical sensitivities.

- To reduce wait time at the reception window, please avoid lengthy conversation, have payment and scheduling tools ready, and avoid taking calls on your cell phone.
- Smoking or e-cigarettes are NOT permitted anywhere in our building.

____ INITIALS

Illegal activity on Barrier Islands Psychiatry property or abusive/threatening language or behavior will result in immediate and permanent discharge from the practice.

____ INITIALS

Please be advised that the patient is responsible for providing a current copy of or updating their insurance card. The patient is responsible for obtaining and providing a referral when required by the insurance company. Without the required information, it is the responsibility of the patient to pay for services rendered on the day of the visit.

Health care regulations require us to collect all co-payments, deductibles, and non-covered service fees or face charges of fraud.

By signing below, I authorize payment of insurance benefits to Barrier Islands Psychiatry for any medical services provided to me. I accept personal responsibility for all services rendered to me, and understand that I am responsible for any charges not covered by my insurance company.

I understand that I will be charged, and agree to pay, for any appointments that I fail to keep and do not cancel at least 24 business hours in advance. I understand that failure to pay as outlined above may result in additional billing, collection agency, and/or legal fees for which I will also be responsible.

_____ _____

Signature of Patient Date

Consent and authority is hereby given to Barrier Islands Psychiatry and its professional staff to perform or have performed examinations and/or psychotherapy and/or related mental health treatments and to administer medications when deemed necessary or advisable by appropriate members of the professional staff in consultation with me. This statement has been fully explained to me (if needed) and I understand it.

_____ _____

Signature of Patient Date

I have been provided a copy of the NOTICE OF PRIVACY PRACTICES and had an opportunity to review it and ask questions.

_____ _____

Signature of Patient Date

I have been provided a copy of the OFFICE POLICIES AND PROCEDURES and had an opportunity to review it and ask questions.

_____ _____

Signature of Patient Date

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Reason you are **seeking care**:

_____

_____

How long have you **suffered with these symptoms**? _____

Have you ever met with a mental health professional? ☐ Yes ☐ No

Where and when?

_____

Have you ever been **treated inpatient at a psychiatric hospital**? ☐ Yes ☐ No

Where/When?

_____

Circle any of the following medications you have ever taken. If effective, put a **check** next to it:

Abilify/Aripiprazole
Adderall/Dextrostat
Ambien/Zolpidem
Amitriptyline
Antabuse/Disulfiram
Ativan/Lorazepam
Buspar/Buspirone
Campral
Celexa/Citalopram
Clonidine
Concerta
Cymbalta/Duloxetine
Daytrana Patch
Depakote/Valproate
Effexor/Venlafaxine
Fanapt/Iloperidone
Fetzima
Geodon/Ziprasidone
Keppra
Klonopin/Clonazepam
Lamictal/Lamotrigine
Latuda/Lurasidone
Lexapro/Escitalopram
Lithium/Lithobid
Lunesta/Eszopiclone
Neurontin/Gabapentin
Paxil/Paroxetine
Pristiq
Prozac/Fluoxetine
Remeron/Mirtazapine
Rexulti
Risperdal/Risperidone
Ritalin
Seroquel/Quetiapine
Strattera
Suboxone/Subutex
Symbyax
Tegretol/Carbamazepine
Topamax/Topiramate
Trazodone/Oleptro
Trintellix/Brintellix
Viibryd/Vilazodone
Vivitrol/Naltrexone
Vyvanse
Wellbutrin/Bupropion
Xanax/Alprazolam
Zoloft/Sertraline
Zyprexa

Please list **other mental health medications** you have taken that were not listed:

_____

Allergies to any medications (describe reaction)? _____

Do you have a **history of substance abuse**? • Yes • No
Which Substance(s)?

_____

Do you **use tobacco** (type/amount)? _____

Do any of your **family members have a mental illness or addiction**?_____

Have you ever had any **surgeries** (please list)? _____

Do you have any **medical problems** (please list)? _____

List **medications you are currently taking**. Please include dose if known:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list your **primary care doctor's name and location**: _____

Other information you wish your provider to be aware of:

_____

_____

_____

Constance Alexander M.D.
Jennifer Hayes, PA - C
Kara Gay, PA - C
Stephen Boice, LISW
Harriet Grady-Thomas, LISW
Shauna Ferrese, LPC

1616 & 1620 Ashley River Road
Charleston, S.C. 29407-5983
Phone: 843.556.8177
Fax: 843-571-2742

Our office requests that a credit card be kept on file for payment of any co-payment, coinsurance, deductible, or charge that may not be covered by your health insurance. This form will be kept confidential and only authorized staff has access to the information.

IF YOU DO NOT WISH TO HAVE A CARD ON FILE, PLEASE PRINT YOUR NAME, WRITE "DECLINE" WHERE IT ASKS FOR THE CARD NUMBER, AND SIGN. PLEASE BE AWARE THAT PAYMENT MUST BE MADE IN FULL AT TIME OF SERVICE.

PATIENT'S NAME: _____

NAME, AS IT APPEARS ON CREDIT CARD:_____

BILLING ADDRESS:_____

_____

EMAIL ADDRESS:_____

AMEX/DISC/MC/VISA CARD #: _____

EXPIRATION DATE: _____ / _____ **VERIFICATION CODE (3 OR 4 DIGITS):**_____

I acknowledge and authorize Barrier Islands Psychiatry to charge the above credit card account for any co-payment, co-insurance, deductible and/or charges not covered by my health insurance provider. I acknowledge that my card will be run in the event payment is not received within thirty days after I receive a statement. I agree to receive billing statements, invoices and receipts via the email I have provided to this office. If I am an uninsured patient I authorize payment at time of service. I agree to update any information regarding this credit card account.

_____ _____

Cardholder Signature Date

Constance Alexander M.D.
Jennifer Hayes, PA - C
Kara Gay, PA - C
Stephen Boice, LISW
Harriet Grady-Thomas, LISW
Shauna Ferrese, LPC

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Consent for Release of Information

I, _____ authorize Barrier Islands Psychiatry to…
(Print name & date of birth)

Disclose Information to / **Obtain** Information from (Circle one)

_____
Name/Agency

_____
Address

_____ _____
Phone Number Fax Number

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (ie: Legal charges of proceedings)

The following Information:

_____ Client Progress Notes
_____ Telephone Exchange of Information
_____ Billing/Payments
_____ Labs
_____ Appointments
_____ Other: _____

_____ _____
Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

PLEASE REVIEW IT CAREFULLY

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make a new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created, and/or received by us before the date changes were made.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know '' standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities. The office reserves the right to communicate with businesses and providers affiliated with our own (The Middle Path and Hammocks On The Edisto) only when it is necessary for your care.

Required By Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of others crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury, and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required by lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards, or letters.