

Welcome,

Please read the following information about financial policies, appointment cancellations, phone calls and emergencies.

Sliding scale fees: Initial Consultation	\$ 110
Return medication visit	\$ 80

Sliding scale is for patients without health insurance who meet the published national income guidelines for a reduction (based upon household income).

Copy of Records: \$20 if patient requests a copy for own use.

Insurance: Be sure to check your health insurance coverage for outpatient mental health care. Usually, there is a yearly deductible and a co-payment for each visit. If you are not eligible at the time services are rendered, you are responsible for full payment. We will file your insurance as a courtesy to you. However, payment is ultimately the responsibility of the patient or the responsible party.

Cancellations & miscellaneous fees not covered by insurance: If an appointment is missed or canceled with less than 24-hours notice, you may be billed directly \$50. The charge for a returned check is \$25. There is a fee of \$10 for completion of FMLA and/or short term disability paperwork, and any letters written on your behalf for your school, lawyer, employer, or preoperative verification of health status. There is a charge of \$10 for any medication prior authorization we are required by your insurance company to obtain. This charge is payable in advance of authorization being obtained. If your account is referred to a collection agency for non-payment, a service charge equal to 30% of the account balance will be added to cover agency fees.

Electronic messages: Once registered, this is the easiest and most convenient way to contact Ms. Eby for questions, medication refills, appointment changes. Available only for non-emergency or administrative issues, Ms. Eby responds to confidential electronic messaging through the secure internet portal at www.patientally.com.

Phone calls: Ms. Eby returns calls by the end of each business day. If you do not hear from her by the end of the day, she did not get the message. Please call again.

Emergency procedures: If you need to contact Ms. Eby, leave a message on her voicemail or send her a message through www.patientally.com. If an emergency arises, go to the nearest Emergency Room or call 911.

Medication refills are electronically sent to your pharmacy on weekdays only if you have a scheduled appointment. Controlled substances are prescribed only at scheduled office visits. No medications are called to pharmacy on weekends, holidays, or nights. You can request an emergency 3-day supply from pharmacy.

Electronic visits are available through www.patientally.com, a portal for your confidential provider message exchange and eVisits. Most insurance companies at this time don't cover the \$35 cost of the visit, which can be paid online with a credit card. Many patients appreciate the convenience of these visits, which are ideal if you can't come to the office for a scheduled appointment. These types of visits are for non-emergencies only and prescriptions are sent electronically to your pharmacy. If it's determined that an office visit is necessary, you will not be charged. For more information about these visits see www.psychiatristknoxville.com for more information.

Signature of Patient or Legal Representative

Date

Access Psychiatry
www.psychiatristknoxville.com

Consent to use and disclose your health information

This form is an agreement between you, _____ and Susan Eby, NP. When we use the word “you” below, it will also mean your child, relative, or other person if you have written his/her name here: _____.

When we examine, diagnose, treat, or refer you we will be collecting what the law calls Protected Health Information about you. We use this information to decide what treatment is best for you and to provide your treatment; or if it is necessary to arrange payment for treatment or for other business or government functions.

By signing this form you are agreeing to let us use your information here and send to others for insurance and billing purposes. The Notice of Privacy Practices explains in more detail your rights and how we can use and share your information.

If you are concerned about some of your information, you have the right to ask us not to use or share some of your information for treatment, payment, or administrative purposes. You will need to inform us in writing.

After you have signed this consent, you have the right to revoke it (in writing) and we will comply with your wishes about using or sharing your information from that time forward.

I certify that the insurance information I provided is correct. I authorize the release of any medical information necessary to process this insurance claim. Additionally, I request payment of medical benefits to the provider for services rendered to the patient named below.

Signature of patient (or guardian)

Date

Printed name of patient (or guardian)

Relationship to patient

Informed Consent for Treatment

I _____ (name of patient), agree and consent to participate in behavioral health care services offered and provided by Susan S. Eby, APRN. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider’s license, certification, and training. If the patient is under the age of sixteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment on behalf of this individual.

Signature _____ Date _____

Relationship to patient (if applicable): _____

Date of Visit:

Health History

Name:

Age:

Marital Status:

Current symptoms:

Age of Onset:

Frequency:

Have you ever received mental health treatment? If so, list dates & provider name: _____

What medications have you tried in the past for mood or nervousness?

Have you ever had a suicide attempt-how many times, when? _____

Have you ever been in a psychiatric hospital or rehab, when? _____

Medical history

Surgeries

What

Current medications, including prescription and over-the-counter: _____

Vitamins/minerals/supplements: _____

Allergic reactions to medications: _____

Family members who have ever been on medications for mood or anxiety: _____

Blood relatives ever in a psychiatric hospital or had a suicide attempt: _____

Tobacco

Never used ___ Packs per day ___

Alcohol

Never used ___ Estimated drinks per day ___

Other drugs

Never used ___ Frequency ___

Caffeine

None ___ How much ___

Birthplace _____ Number of siblings _____ Grade completed _____

Training, military, or education beyond high school: _____

Occupation: _____

What hobbies or interests do you have? _____

How often do you exercise? _____

With whom do you live? _____ Sons ages: _____ Daughters ages: _____

Access Psychiatry

www.psychiatristknoxville.com

130 Mabry Hood Road NW Suite 103 Knoxville TN 37922

Phone: (865) 314-7002 Fax (865) 622-7090

Patient Registration

Date _____ Name _____

Social Security Number _____ Age ____ Date of Birth _____

Preferred phone: _____ () cell () home () work () other

OK to leave detailed messages on this phone? () yes () no

Other phone: _____ () cell () home () work () other

OK to leave detailed messages on this phone? () yes () no

Appointment reminders by () phone _____ and/or email () _____

Mailing address: _____

Street address, if different: _____

Referred by: _____

Address & Phone of referrer, if another provider: _____

Current therapist, if not referrer: _____ Therapist phone _____

Primary care provider: _____ PCP phone _____

PCP Address: _____

Pharmacy used, if applicable: _____ Pharmacy address: _____

Patient employer: _____

Emergency contact (relationship & phone): _____

Person responsible for payment, if other than patient:

Name: _____ Address: _____ Phone: _____

Insurance Verification Acknowledgement (if applicable)

I certify that the insurance information I provided is correct. I authorize the release of any information regarding my evaluation or treatment necessary to process the insurance claim. I authorize the release of pertinent information required by my Managed Care Company for treatment plans and summaries. I authorize the payment of benefits to the provider for services provided.

Signature

Date

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Member Rights and Responsibilities Statement

Statement of Members Rights: You have the right...

- To be treated with dignity and respect.
- To fair treatment; regardless of their race, gender, age, ethnicity, sexual preference, disability, or source of payment.
- To have your treatment and other information kept private. Only where premitted by law, may records be released without member permission.
- To be protected from neglect, physical emotional or verbal abuse and from all manner of exploitation.
- To be informed of the side effects of the medication prescribed or proposed for prescription.
- To access timely care in a timely fashion.
- To information in a language you can understand.
- To a clear explanation of your condition and treatment options.
- To information about your practitioners services, and role in the treatment process.
- To ask about clinical guidelines used in providing and managing your care.
- To ask your provider about their work history and training.
- To know about advocacy and community groups and prevention services.
- To freely file a complaint or appeal about insurance, staff, services, or care given by provider.
- To know of your rights and responsibilities in the treatment process.
- To receive services that will not jeopardize your employment.
- To list certain preferences in a provider.
- To refuse to participate partially or fully in treatment or theraputic activities, unless participation is court ordered.
- To know all the facts about any bill or charge you receive

Statement of Members Responsibilities: You are responsible ...

- To treat those giving you care with dignity and respect
- To give providers accurate information, in order for provider to be able to deliver the highest level of patient care.
- To learn about your condition and work with your provider to develop a plan of care.
- To tell your provider and primary care physician of any medication changes that occur, including medications given to you by others.
- To keep your appointments and to cancel appointments you are unable to keep.
- To let the provider know when the treatment plan is not working for you.
- To report abuse and fraud.
- To openly report concerns about the quality of care you receive.
- To let your provider know about problems with paying fees.

My signature below shows that I have read, been informed of and understand this Statement of Members' Rights and Responsibilities.

Member Signature

Date

The signature below shows that I have explained this statement to the patient and have provided comprehensive answers to all patient questions. I have offered the patient a copy of this form.

Provider Signature

Date

Access Psychiatry

www.psychiatristknoxville.com

CREDIT CARD BILLING AUTHORIZATION FORM

If you prefer the convenience of automatic billing to your Visa, Master Card or Discover Card, simply fill out the information below. Upon approval, we will automatically bill your credit card for the amount due and your total charge will appear on your credit card statement. You may cancel automatic billing at any time.

PATIENT NAME

--

CREDIT CARD INFORMATION

VISA

MASTER CARD

DISCOVER CARD

NAME PRINTED ON CARD	
BILLING ADDRESS	
CITY, STATE, ZIP	
DAY TIME PHONE NUMBER	
CREDIT CARD NUMBER	
3 DIGIT CODE <i>ON BACK OF CARD (CVA#)</i>	
EXPIRATION DATE ON CARD	

I authorize Susan Eby to bill my credit card per the instructions below:

Bill my account one time for \$ _____
Bill my account for the balance due. Y / N (circle one)

This authorization is valid for one year from this date. _____
OR
This authorization is valid until this date. _____

Signature: _____

Susan S. Eby, APRN.
130 Mabry Hood Road NW, Suite 103
Knoxville, TN 37922
Phone (865) 314-7002

AUTHORIZATION TO RELEASE OR REQUEST PATIENT INFORMATION

Patient's Name:
Date of Birth:
I do__ or do not __ authorize Susan S. Eby, APRN to release/request information about myself to/from my provider/s listed below:
Name:
Address:
Phone:
The above section must be checked as to whether it is OK to contact other providers about treatment.
for the following purpose(s): Coordination of Care
This consent expires one year from today's date
or as specified as follows:

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulation. I also understand that I may revoke this consent at any time except to the extent that action has already been released in reliance on it.

PATIENT SIGNATURE

WITNESS SIGNATURE

PARENT OR GUARDIAN SIGNATURE

TODAY'S DATE

Access Psychiatry
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About email communication from the clinic

We recognize the importance of protecting the privacy of all information provided by the visitors, patients, and business associates who visit the website. Ms. Eby requests your email address so that she may communicate with you about general updates and services, such as snow days or sick days at the clinic, causing the clinic to be closed. And email notices can serve as appointment reminders.

If you'd like to add your email address, please add here: _____

About Email communication between you and your provider

Email is a great way to stay in touch between office visits, to ask questions, or to make changes to your next appointment. Ms. Eby offers two types of email communication.

Email communication is generally considered unsecure unless you communicate through a closed portal. Ms. Eby works with www.Patientally.com to supply a secure portal for her patients so that you can feel confident that your privacy is protected. You can access this secure portal for non-emergency issues through her website www.psychiatristknoxville.com.

There is also a general email link on her website, best used for non-medical, non-emergency questions, such as appointment changes. Because this link may not be secure, please use the Patientally.com portal for more confidential communication. If you decide to use the non-secure email link on her website, be aware that the communication may be compromised, similar to someone listening-in on a private phone conversation.

You may use either email link offered on her website, and by signing below, you verify that you understand the privacy difference between the email choices offered above.

Signed: _____

Date: _____