EVERLY, HILDRETH & PLATMAN BEHAVIORAL SERVICES, LLC

PRIMARY CARE PHYSICIAN (PCP) AUTHORIZATION FORM

FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (please print): _____

Date of Birth: _____ Social Security Number: _____

By signing this authorization form, I understand that I hereby request and authorize, EHP Behavioral Services, LLC, to release or receive verbally or in writing my protected health information, as described in more detail in the paragraph below, to the following primary care physician:

NAME OF PRIMARY CARE PHYSICIAN: _____

Street address: _____ City: _____ State: _____ Zip code: _____

Telephone number: _____ Fax number: _____

PURPOSE OF THE USE AND DISCLOSURE: Communication necessary for treatment and coordination of care.

SPECIFIC DESCRIPTION OF INFORMATION: Information pertaining to patient's treatment, current status, symptoms, diagnosis, and medications.

I understand that I may revoke this authorization at any time by providing a written notice to EHP Behavioral Services, LLC, 8114 Sandpiper Circle, Suite 215, Baltimore, MD 21236. I also understand that such a revocation will have no effect on any information already used or disclosed by EHP Behavioral Services, LLC prior to the receipt of such notice. Unless earlier revoked, this authorization will expire twelve (12) months after date of termination or as otherwise specified:_____

If neither Federal nor Maryland privacy law applies to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by Federal or Maryland privacy law.

This authorization is voluntary and I may refuse to sign this authorization form. I understand that I am not required to sign this authorization form in order for the patient to receive treatment from EHP Behavioral Services, LLC. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the primary care physician named in this form.

_____Release any applicable mental health/substance abuse information to my PCP named above.

_____**DO NOT** release any information to my PCP named above. Reason: _____

_____ _____

Signature of Patient or Personal Representative | Date

_____ _____

Printed Name of Patient | Relationship to patient giving representative authority to act for patient *(if applicable)*

The Johnston Professional Building
3333 N. Calvert Street, Suite 670
Baltimore, MD 21218
(410) 243-8640
(410) 243-5642 Fax

Union Memorial Hospital Counseling Center
3300 North Calvert Street
Baltimore, MD 21218
(410) 554-6600
(410) 554-6603 Fax

The White Marsh Health Center
8114 Sandpiper Circle, Suite 215
Baltimore, MD 21236
(410) 933-9000
(410) 933-9085 Fax

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Patient Disclosure of Health Care Information

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information. The individual is also provided the right to request confidential communications or that a communication of Private Health Information be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

It is our policy to contact the patient using the Primary Telephone Contact Number (as listed on the Patient's Information/Initial Demographics Sheet), and if necessary, using the Second Telephone Contact Number. It is also our policy to leave a detailed message if necessary. Please note below if you want any exceptions to our policy.

_____

_____

Acknowledgement of Welcome to EHP Behavioral Service, LLC Brochure

I acknowledge that I have read and understand the "Welcome to EHP Behavioral Services, LLC" brochure including the following: Our responsibilities; Your responsibilities; Concerns or Questions; Appointment Confirmations; Office Hours; Emergency Procedures; Prescription Refills; HIPAA Compliance and Information Release; and Cancellations and Missed Appointments.

Acknowledgement of Receipt of Notice

As required by the Privacy Regulations, I hereby acknowledge that I have received a current copy of EHP Behavioral Services' "Notice of Privacy Practices."

As required by the Privacy Regulations, a staff member from EHP Behavioral Services has explained the "Notice of Privacy Practices" to my satisfaction.

As required by the Privacy Regulations, I am aware that EHP Behavioral Services has included a provision that it reserves the right to change the terms of its notice and to make the new notice provisions effective for all protected health information that it maintains.

As in our "Notice of Privacy Practices," we may disclose your healthcare information to other healthcare professionals for continuity of care. We may also need to disclose it to billing staff, legal counsel and insurance companies for the purpose of treatment, payment or healthcare operations. If you wish to file a "Request for restriction", please check box and see patient service representative for appropriate form.

Patient or Legal Guardian Signature: _____Date: _____

Patient Name **(Print):**_____Date of Birth: _____

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Financial Policy

Thank you for choosing EHP Behavioral Services, LLC as your health care provider. Our practice is committed to delivering the best treatment possible for each of our patients. Your clear understanding of our financial policy is important to our professional relationship, and allows us to concentrate on patient care.

Insurance

We must emphasize that as medical care providers, our relationship is with you, the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges from the date the service is rendered are your responsibility. Your insurance is a contract between you, your employer and your insurance company. We are not a party to the contract.

Payment for office visits is due at the time of service. However, we will bill office procedures to your insurance company of record as a courtesy. **Your insurance company may send the payment to you, the insured, not the provider. Please endorse the back of the check and write "Payable to EHP Behavioral Services, LLC" below your signature. You must then forward both the insurance check and the accompanying explanation of benefits to EHP Behavioral Services, LLC, 8114 Sandpiper Circle Suite215 Baltimore, MD 21236 as soon as you receive it. This is imperative so that our billing office can accurately reconcile your account.** We accept cash, checks and credit cards. If we do not have a copy of your most current insurance on file, you will be considered a self-pay patient and will be expected to pay at the time of service. Please remember to bring your insurance card with you to each appointment.

Canceled Appointments

It is important that you keep your scheduled appointments. If you are unable to do this, please call the office at least 24 hours in advance so that another patient can be accommodated in that time slot. If you do not show for a scheduled appointment, or cancel less than 24 hours in advance, you will be charged **$50.00.**

Workers Compensation/No Fault

Any charges incurred for this treatment are ultimately the responsibility of the patient. Payment for the patient will be expected until the practice is provided with all the information necessary to submit a claim.

Form Completion Policy

EHP Behavioral Services, LLC requires payment for the completion of requested paperwork (forms/letters). We receive many requests which require increased administrative time and financial resources in excess of what is normally needed to complete the medical record. We will make every effort to complete requested paperwork within 5-7 business days; however, we cannot make any assurance of completion within the patient's time frame(s). At the provider's discretion, paperwork may be completed in session. Otherwise, payment is required prior to completion of all requested paperwork. Most paperwork will be assessed a **$25 fee** for completion. Examples usually include: Family Medical Leave Act (FMLA), Letter of Condition, or miscellaneous requests. If any requested paperwork is over two pages in length or would exceed six minutes to complete, the provider, at his/her discretion, may charge based on the hourly rate of $250 per hour **($4.167 per minute)**. Examples include but are not limited to workers compensation forms, and comprehensive patient history detail.

If you have any questions or need any additional information regarding our financial policy, please do not hesitate to call our billing office at (410) 933-9000.

I have read and understand the above financially policy.

_____ _____

Patient Signature Parent/Guardian Signature

_____ _____

Patient Name (print) Date

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