MHP
MILE HIGH PSYCHIATRY

Helping You Become the Best You

Patient Referral Form:

Patient Name:_____ DOB:_____

Patient Phone:_____ Insurance:_____

Patient Presenting Concerns:

_____

Services referred for: Medication Management ☐ Therapy ☐

Previous Mental Health Hospitalizations? Yes ☐ No ☐ If so, when _____

Current Medications:

_____ _____

_____ _____

_____ _____

Physical or Mental Impairments? Yes ☐ No ☐

Currently seeing a therapist? Yes ☐ No ☐

Any additional information that is important for proper care?

_____

Referred by: _____

Please email all referrals to marketing@milehighpsychiatry.com and attach any supporting documents that may be needed to ensure proper care. If you have any questions please call us at 855-675-1751.

Mile High Psychiatry Corporate Office- 14221 East 4th Avenue 2-126 Aurora, CO 80011

At Mile High Psychiatry, we provide a range of mental health services for both children and adults, exclusively through telehealth. By utilizing and integrating multiple therapeutic modalities, our providers will work with you or your child to develop a plan of care that emphasizes wellbeing, collaboration, and patient empowerment.

MHP
MILE HIGH PSYCHIATRY

Child, Adolescent and Adult Psychiatric
Medication Management Services

POLICIES AND CONSENTS

14221 East 4th Ave, Suite 2-126 Aurora, CO 80011
Office: 720-507-4779 Fax: 720-367-5067

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aurora@milehighpsychiatry.com - www.milehighpsychiatry.com

O: (720) 507-4779 F: (720) 367-5067

TREATMENT CONSENT FORM

* Please read carefully and sign to confirm you have read, reviewed and agree to our practice policies and procedures *

Services Offered

Psychotherapy

Psychotherapy or talk-therapy, is a powerful treatment for many mental complaints. It offers benefits of improved interpersonal relationships, stress reductions and a deeper insight into one's own life, values, goals and development. It requires a great deal of motivation, discipline and work from both parties for a therapeutic relationship to be an effective one. Clients will have varying success; depending on the severity of their complaints, their capacity for introspection and their motivation to apply what is learned outside of sessions.

Clients should be aware that the process of psychotherapy may bring about unpleasant memories, feelings and sensations; such as guilt, anger or sadness, especially in its initial phases. It is not uncommon for these feelings to have an impact on current relationships that you may have. If this occurs, it is very important to address these issues in session. Usually these unpleasant sensations are short lived. At your initial visit, we will conduct a thorough review of your current concerns and of your background. By the end of the initial visit we will offer our preliminary impressions, discussing your treatment options. Sometimes psychotherapy and medication management are optimal (see below). One of the most important curative aspects of the therapeutic relationship is the goodness-of-fit between provider and client. The initial visit is also your opportunity to determine for yourself if we are the right provider for you. If you feel that we are not well matched to your needs, we would be happy to provide you with referrals to other mental health professionals.

Here at Mile High Psychiatry our providers have the capability of providing therapy to clients, but do not normally include this service in each session. If this service is provided, the providers will bill for their time. Any session that goes over 15 minutes time due to psychotherapy or any non- medication concerns and discussions, will be charged a psychotherapy fee based on the amount of time spent with the provider.

Medication Management

Medications may be indicated when your mental health symptoms are not responsive to psychotherapy alone. When a mental illness markedly impacts your ability to work, maintain interpersonal relationships or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, we will discuss medication options that are available to treat your current condition. We will present information in a language that you can understand. You will learn how the medication works, its dosage and frequency, its expected benefits, possible side effects (even life threatening ones), drug interaction and any withdrawal effects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all of the information that you need to make a rational decision as to which medication is right for you.

You may already be receiving psychotherapy from another therapist and were referred to us for medication management. In this case, we will make a strong effort to coordinate care with your therapist with your written consent. We believe that communication between mental health professionals is the key to providing effective care.

If at any point during your care you would like a second opinion, you are encouraged to do so. Our MHP team can assist in recommending another internal or external provider to review your care and treatment plan. It is your responsibility to inform your current provider or MHP team of any pertinent information that may affect your care.

Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage and frequency, close follow up and sometimes regular blood and/or urine tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy. Overall, we are here to support you in the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development and social issues will yield the best chance for success in achieving your goals.

Pregnancy

Our practice strives to treat any and all clients however, pregnancy and attempting to become pregnant while on medications that we prescribe has risks up to and including death of the fetus and/or mother. As such, most medications while pregnant or trying to become pregnant are contraindicated and are advised not to be used. If you are pregnant or would like to become pregnant, you must disclose this information to your provider. If we have decided to provide care while pregnant, it is REQUIRED that you also have an OBGYN of whom we will consult prior to providing any medications or medication changes.

Frequency and Duration of Visits

At your initial thirty to sixty minute visit, we will decide the structure of your treatment together. If medications are prescribed or changed, we prefer to conduct a fifteen to thirty minute follow up visit within the next two weeks. This is necessary to ensure the proper administration and to minimize any side-effects you may experience. If your symptoms improve, follow up visits can be spaced out at monthly intervals. For clients on maintenance therapy, follow up visits can be held at three month intervals. If you are to undertake psychotherapy, weekly fifty minute sessions will provide the best results. We may discuss an alternate treatment structure depending on your circumstances.

Fees

For a thirty to sixty minute initial evaluation, our standard fee is $275.00 - $305.00. This does not include any additional add-ons such as psychotherapy, coordination of care, etc. Follow up psychotherapy or combinations (psychotherapy and medication management) visits will last up to thirty minutes and will cost $175.00 - $225.00 (depending on the complexity of your visit). Other miscellaneous services such as completing forms, telephone correspondence, prior authorizations, court hearings, the transfer of medical records, etc., of which require more than ten minutes of time may cost from $30.00- $50.00. Fees may be subject to change. If fees are to increase we will provide you a thirty day notice to alert you to the change. Please talk to our office regarding cash rates and payment plan options.

If a balance is added to your account, you will be provided a billing statement with a thirty day grace period to make a payment. If the payment requested is not received within this thirty day time period, a late fee will be assessed and may be added to your account. Please be sure to contact our billing department as soon as you are able in order to set up a possible payment arrangement if you are experiencing any difficulties making payments. By signing this form you agree to the terms and conditions of our late fee policy.

Payments

Payments will be paid at the time of service, unless we have agreed on other arrangements. We accept personal checks, cash, credit or debit cards and money orders. Checks should be made payable to Mile High Psychiatry, LLC. If a payment is 90 days past due, we reserve the right to utilize legal resources such as collection agencies or small claims courts in order to obtain payment for our services.

If your account is submitted to a collection agency, a 40% collection fee will be added to your outstanding balance upon submission to the agency. By signing this form, you agree to this charge.

Cancellations and No-Shows

If you must cancel or reschedule an appointment, we require at least 24 hour notice (weekends not included). For example, if your appointment is on a Monday, - the

cancellation must be made by the same hour on the preceding Friday. Cancellations that occur with less than 24 hour notice or if you fail to show up to an appointment, you will be charged up to a maximum of $75 for the session if seen for medication management services or up to a maximum of $100 for therapy services. Payment for the cancellation fee must be paid before rescheduling the next appointment. Continued cancellations and/or changing appointments by a client may result in the cancellation of continued services.

Our providers reserve the right to cancel the relationship at any time if the client becomes non- compliant with care, is belligerent, disrespectful, a danger to the provider, malingers or otherwise is harmful to the practice in any way. If there is a negative balance that is owed, the balance must be paid prior to or at the time of the next visit. If continual cancellations and repeated non-payment occurs, treatment will be discontinued. You will be notified of discontinuation of care via mail, telephone call or email. If you as the client choose to cancel your relationship with Mile High Psychiatry, it is required that you complete an exit interview. The purpose of this interview is to discuss proper discontinuation methods of medications and/or offering other medication options.

Insurance

We currently accept various insurance policies. We encourage all of our clients to contact your insurance company prior to your visit with Mile High Psychiatry to confirm active coverage. We will be considered “out of network” if we do not participate with your insurance plan. If you wish to be reimbursed for your sessions, you will need to consult your insurance company to determine their policies regarding mental health benefits for out of network providers. We will provide you with a paper “super bill” that can be submitted to your insurance company for the possibility of reimbursement from your insurance provider.

Many insurance companies have limitations on the number/ frequency of visits and types of medications that will be covered. Occasionally, certain forms of treatment or a large number of sessions require a prior authorization. If this is the case we may need to provide information about your diagnosis, history and treatment plan to your insurance company. Once this information is provided it will be subject to the privacy policies of the insurance provider and is out of our control.

Medical payment liability is the responsibility of the client if the insurance company denies the fee for service or does not pay the full rate. The client will be responsible for the TOTAL unpaid balance should insurance not pay the full cost of appointment(s).

Medical Records

We are required by law to keep complete medical records. Your medical records will be electronic and secure. Any written records including the initial consent forms, letters or anything outside of medical records will be kept in a secure location. You

have the right to request that a copy of your medical records be made available to any other health care provider at your written request. You are also entitled to review your medical record at any time unless we feel that by viewing your records your emotional or physical well-being will be jeopardized. If you wish to view your records, we recommend that you review them together with your provider to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying and summarizing the medical record will be charged the appropriate fees (see fees). If medical records/progress notes are required for court documentation, copies will only be provided with a court ordered subpoena. Any other paperwork completion request besides medical records, requires a minimum of four visits.

Patient Rights and Grievance policy:

Mile High Psychiatry aims to alleviate patient concerns and issues by establishing the ideal avenues to express grievances. Mile High Psychiatry patients will be supported. Any patient of MHP who shares concerns will be assisted in a timely and efficient manner, with solutions offered to their grievances. Patients who would like to share direct feedback and/or express any concerns they may be facing regarding their care- please call Mile High Psychiatry directly at (720) 507-4779. Patients may also email our administrative team at aurora@milehighpsychiatry.com. Another way to contact us directly regarding a grievance is to visit our website and submit a fillable form at https://milehighpsychiatry.com/.

Refusal of Treatment:

As a patient of Mile High Psychiatry, you have the right to refuse treatment. You will be advised of your provider's full recommendation for treatment and have the opportunity to deny such recommendations. Mile High Psychiatry providers will fully explain the nature, purpose, risks and benefits of the proposed treatment, the possible alternatives thereto, and the risks and consequences of not proceeding. As a patient, you will have the opportunity to ask questions and have all of your questions answered satisfactorily. Should you refuse and deny medication management treatment from Mile High Psychiatry providers, you are releasing the practice, its employees and the attempting physician from any liability for all ill effects that may result from your decision to refuse to consent to the proposed treatment.

Confidentiality

The security of your sensitive information is of the utmost importance to us. We are bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary.

We are required to follow the regulations set forth by HIPAA. We strictly adhere to these regulations and cannot disclose any information without first verifying your name, date of birth and social security number.

Your session may be video or audio recorded for training and quality improvement. Mile High Psychiatry staff and providers do NOT allow permission to be filmed or audio recorded during any session, within the premises, on the phone, video conference or any form of interoffice communication.
There are exceptions to this confidentiality where disclosure is mandatory. These include the following:

- If there is a threat to the safety of others we will be required by law to take protective measures; including reporting the threat to the potential victim, notifying the police and seeking hospitalization
- When there is a threat of harm to yourself, we are required to seek immediate hospitalization and will likely seek the aid of family members or friends to ensure your safety
- In legal hearings you do have the right to refuse involvement in the hearing. There are rare circumstances however, in which we will be required by a judge to testify on your emotional or cognitive condition
- In situations where a dementing illness, epilepsy or other cognitive dysfunction prevents you from operating a motor vehicle in a safe manner, we will be required to report this to the DMV
- If mental illness prevents you from providing for your own basic needs; such as food, water or shelter we will be required to disclose information to seek hospitalization.

These situations rarely occur in an outpatient setting. If they do arise, we will do our best to discuss the situation with you before taking action. In rare circumstances, we may find it helpful to consult with other professionals specialized in such situations (without disclosing your identity to them).

Our Practice

If you see one of our providers for psychotherapy or if you are referred to another community therapist or physician, we may find it helpful to collaborate and coordinate your care. This will require written consent and release of information. Any clinician to whom we refer you will be responsible for the care that they provide you.

Contact Information

If you or someone you know is experiencing a Medical or Psychiatric emergency, please call 9-1-1 or proceed to the nearest hospital. Our voicemail at (720) 507-4779 is the best way to contact us outside of our regular office hours. When you leave a message please state your name clearly, your phone number (even if you think we have it), the reason for calling and the best time to contact you. For non-urgent matters, please allow 24 business hours for a response. Messages left late in the day, on weekends or holidays may not be returned until the next business day.

MILE HIGH PSYCHIATRY

Consent for Tele-Psychiatry

* Please read carefully

Tele-Psychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location. The interactive electronic systems used in Tele-Psychiatry incorporate network and software security protocols to protect the confidentiality of client information and audio and visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Telepsychiatry may be appropriate and possible for certain situations and medical needs, while not appropriate or possible in others. The use of Tele-Psychiatry will be determined on a case-by-case basis by the provider. The provider will always act in the best interest of the patient and shall place the health, safety, and welfare of the patient first when making a determination on the use of Tele-Psychiatry.

Potential Benefits:

- Increased accessibility to Psychiatric care
- Increased continuity of care between provider and patient
- Client convenience

Potential Risks:

Due to the inherent limitations of Tele-Psychiatry, there may be potential risks associated with the use of Tele- Psychiatry. These risks include, but may not be limited
to:

- Information transmitted may not be sufficient (e.g. poor resolution of video, hardware, software, or equipment problems) to allow for appropriate decision making by your provider
- Your provider may not be able to provide medical treatment using interactive electronic equipment nor provide for or arrange for emergency care that you may require
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment
- Security protocols protecting confidential information can be more at risk, causing a breach of the privacy of confidential health information - A lack of access to all the information that might be available in a face to face visit but not in a Tele-Psychiatry session, may result in errors in judgment

Client Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to Tele-Psychiatry

- I have the right to withhold or withdraw my consent to use Tele-Psychiatry during the course of my care at any time. I understand that my withdrawal of consent will not affect my future care or treatment
- I understand that my provider has the right to withhold or withdraw consent for the use of Tele-Psychiatry during the course of my care at any time - I understand that all rules and regulations that apply to the provision of healthcare services in the state of Colorado also apply to Tele-Psychiatry

Client Responsibilities:

- I will not record any Tele-Psychiatry sessions without written consent from my provider
- I will inform my provider if any other person can hear or see any part of our session before the session begins. The provider will inform me if any other person can hear or see any part of our session before the session begins
- I understand that I alone am responsible for the configuration of any electronic equipment used on my electronic device that is used for Tele-Psychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins
- I understand that I must be a resident of the State of Colorado to be eligible for Tele-Psychiatry services from my provider
- I understand that I must be physically in the State of Colorado at the time of any scheduled Tele-Psychiatry appointment

MILE HIGH PSYCHIATRY

Prescription Policy

* Please read carefully

- No prescriptions will be refilled on Saturday, Sunday or major holidays
- We require 3 business days minimum to process prescription(s) renewals/requests
- The client is responsible for knowing when medication(s) will need to be refilled (no early refills)
- Prescription refill phone-in: Monday – Thursday during business hours ONLY (8:00AM – 5:00PM)
- Prescriptions will not be filled for unauthorized "walk-in" clients. A call with a voice message is required for these cases
    - **Note: The provider may be inaccessible due to scheduled client needs**
- Non-controlled/non-narcotic prescriptions require a follow up appointment every 3-6 months
- Controlled-substances/narcotic prescriptions require a follow up appointment every 30-90 days
- New symptoms and/or events require a clinic appointment. The provider is unable to diagnose via phone
- No early refills if medications are overused, abused, misused, lost or stolen - Client must follow prescription directions
- If it is found that medications are being provided through multiple providers for controlled substances or narcotics, Mile High Psychiatry reserves the right to dismiss the client. This is defined as drug diversion and/or misuse of medications.
- Medications are for the prescribed individual's use only. It is illegal to "share" your medicine
- NO controlled substances or stimulants will be provided as "bridge" scripts. You MUST keep your scheduled appointments in order to receive refills for these medications!

These protocols are per recommendations of the Colorado Board of Regulatory Agencies and DEA

I understand and accept the protocol listed above. Failure to comply may subject immediate termination of prescriptive medications. I also agree to random and/or regular lab testing via blood or urine to ensure the above guidelines are not being violated.

We strive to offer the best services and care for each client in a timely manner. The above "rules" are essential and necessary to efficiently manage your care.

Thank you in advance for your cooperation and understanding,

Your Mile High Psychiatry Team

MILE HIGH PSYCHIATRY

Attendance Policy

* Please read carefully

Mile High Psychiatry is dedicated to providing quality care to our clients and are pleased to reserve an appointment time exclusively for you. For your convenience, we will make every attempt to meet the needs of your personal schedule. We reserve time exclusively for you and ask that you make every effort to attend your reserved appointment.

- A scheduled appointment MUST BE CANCELED AT LEAST 24 HOURS IN ADVANCE to avoid being charged
- Last minute cancellations, reschedules and no-shows will be charged up to the full cost of the scheduled appointment
- If a client is late for an appointment, the appointment may be canceled and rescheduled; resulting in the client being charged up to the full amount of the scheduled appointment
- All cancellations and absences will be documented in the client medical records
- THREE absences (cancellation, reschedule, no show) or tardy appointments in a six month period may result in adjusting your appointment policy or discontinuation of care
- ALL FEES MUST BE PAID IN FULL PRIOR TO YOUR NEXT APPOINTMENT

Provider Cancellation Policy

- In the case of a provider canceling an appointment(s), no charge or fee will occur and all affected client(s) will be notified immediately
- We will attempt to reschedule your appointment at our earliest convenience

Appointment Reminders

We aim to make your appointment process seamless and easy. We offer three options of appointment reminders: text message, phone call and email. It is completely up to you how you will receive these reminders and can change your preferred method at any time. Please be advised that these reminders are sent through an automated system anywhere from 8:00am to 5:00pm, with the exception of the phone call from an in-office representative.

Provider's Hours of Operation

Monday - Friday: 8:00AM - 6:00PM

MILE HIGH PSYCHIATRY

Advanced Directives

* Please read carefully

What is an Advanced Directive?

Advance Directives are written instructions a person completes that tells Medical Providers what to do if they become incapacitated and can't make those decisions for themselves.

For example a person might not want to be placed on life support if they are in an accident or in another serious medical event. Any competent adult in Colorado (age 18+) can obtain an Advance Directive.

Advanced Directives help you to:

- Protect your right to make medical decisions about your healthcare - Help your family members make decisions if you are not able to
- Help your providers by telling them your wishes

Why do I need an Advance Directive?

Federal Medicaid regulations and Colorado State law recognize the right of competent adults to make decisions regarding their medical care, including their right to accept or reject medical treatment. These laws further require organizations to ask you if you have an Advance Directive. You do not have to have an Advance Directive to receive services from any provider. Advance directives say what kind of medical care you want if you get too sick or hurt to talk or think clearly. The State of Colorado gives you the right to have an advance directive if you are 18 or older.

There are four (4) kinds of Advance Directives:

1. Living Will: A Living Will tells your doctor whether to use artificial life support (medical help) if you become "terminally ill" (sick enough that you are expected to die). Copies of Living Will forms are at healthcare facilities, providers' offices and office supply stores. You can also get them at the Guardianship Alliance of Colorado by calling: (303) 228-5382
2. Durable Power of Attorney: A durable power of attorney is a person you choose to make healthcare choices for you if you cannot speak for yourself
3. CPR Orders/Do Not Resuscitate (DNR) Order: CPR Orders/DNR order allows you to choose how to instruct medical staff on performing life saving measures if your heart stops beating and/ or you stop breathing on your own. For example, you may tell them to not perform CPR
4. Proxy Decision Maker for Medical Treatment: A proxy decision maker for medical treatment can make decisions on your behalf if you are unable to make an informed consent, refusal or discontinuation of medical treatment

If you would like to obtain additional information on Advance Directives, please visit: http://www.coloradoadvancedirectives.com/

What Happens if Your Advance Directive Is Not Followed?

In the event that an attending physician or health care facility refuses to comply with an Advance Directive on the basis of moral convictions, religious beliefs or other conscientious objections, the individual will be transferred to the care of another health care provider willing to comply with the Advance Directive.

- Call the Colorado Department of Public Health and Environment at (303) 692-2980
- Write to: Colorado Department of Public Health and Environment, 4300 Cherry Creek Drive South Denver, CO 80246 or go to their website: https://www.colorado.gov/cdphe

If you have an Advance Directive it is your responsibility to provide a copy of the document to any organization you are seeking medical/behavioral health services at the time of intake or as soon as possible following your intake. The document will then be placed in a prominent location in your medical record. If you ever revoke or change your Advance Directive, you must inform your care coordinator as soon as possible so your information can be updated in your medical record. You will get more information on advance directives if you are admitted to a hospital. You are not required to have one. If you decide to have an advance directive, it is important to talk to your provider. You should also talk with family and people who are close to you. Be sure to give copies of your directive to your provider, family members and durable power of attorney (if you have one).

I have read and understand the information about advance directives provided to me.

☒ I do not have advance directive

** If you would like to complete Advanced Directives paperwork, please feel free to request the necessary forms from our staff **

By signing below, you certify that you have read and understand the terms as stated in the Treatment Consent Form, Prescription Policy, Consent for Tele-psychiatry, Attendance Policy and Advanced Directives. You Indicated that you understand the scope of our services, session structure, fees, cancellation/no –show policies, payment policy, insurance reimbursement, confidentiality, the nature of our practice, our contact information and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

We are looking forward to Helping you Become the Best You!

Client Name (Printed): _____

Client Signature: _____

Date: _____

Mile High Psychiatry, Corporate Offices
14221 East 4th Avenue 2-126
Aurora, CO 80011
Phone: 855 675-1751

Patient Demographic Form

Last Name | First Name | Middle | Nickname

__/__/__ ❑ Male ❑ Female ❑ Non-Binary
DOB | Gender | SSN

❑ Married ❑ Single
Marital Status | Ethnicity | Preferred Language | Preferred Pronouns

Home Address | Apt # | City | State | Zip Code

Home Phone | Cell Phone | Work/School Phone

Email Address | Referral Source *(Please Specify)*

Employer/School Name

Emergency Contact Information

Last Name | First Name | Relationship to Patient

Home Address | Apt # | City | State | Zip Code

Home Phone | Cell Phone | Work/School Phone

Email Address

Insurance Information

Primary Insurance | Member ID | Secondary Insurance

Preferred Pharmacy | Phone Number | Address

Responsible Party/Guarantor Information

Relationship to Patient: ❑ Self (If Self, skip this section) ❑ Spouse ❑ Parent ❑ Other

❑ Male ❑ Female
Last Name | First Name | Middle Initial | Gender

Home Address | Apt # | City | State | Zip Code

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O: (720) 507-4779 F: (720) 367-5067

ACH Authorization Form

CREDIT/DEBIT AUTHORIZATION FORM (This form is NOT optional)

I hereby authorize Mile High Psychiatry to withdrawal via credit/debit card and, if necessary, initiate adjustments for any transactions credited/debited in error. This authority will remain in effect until Mile High Psychiatry is notified by me (us) in writing to cancel it in such time as to afford Mile High Psychiatry a reasonable opportunity to act on it.

***** I also authorize my credit/debit card to be used in the event of a missed appointment or last minute reschedule/cancel appointment. I agree to the full cost of the visit ($175 - $220 for follow up visits and $275 - $305 for intake visits). *****

Card holders name: _____

Card Holders Address: _____

Patient Name: _____

Card Number

Expiration Date: _____ CVV: _____

* American Express has 15 digits, with a 4 digit CVV *

Cardholder's Signature: _____ Date: _____

MILE HIGH PSYCHIATRY

HIPAA Privacy Release of Information Authorization Form

Patient Name: _____ Patient DOB: _____

1. I hereby authorize all medical service sources and health care providers at Mile High Psychiatry to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named _____. (If there is no power of attorney designated, leave blank)

2. Authorization for release of PHI covering the period of Health Care (check one)
   A. ❑ From (date) _____ to (date) _____
   B. ❑ All past, present and future periods

3. I hereby authorize the release of PHI as follows, (check one)
   A. ❑ My complete health record (including records relating to Mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse)
   B. ❑ My complete health record with the exception of the following Information: (check all that apply)
      _____ Mental Health Records
      _____ Communicable Diseases (including HIV or AIDS)
      _____ Alcohol/Drug abuse
      _____ Lab Results
      _____ Other (please specify) _____

4. I authorize disclosure of information regarding my billing, condition, treatment and prognosis along with my PHI as described in paragraph 3A and 3B to the following individuals:

Name: _____ Phone: _____-_____-_____ Relationship:_____

Name: _____ Phone: _____-_____-_____ Relationship:_____

Name: _____ Phone: _____-_____-_____ Relationship:_____

5. This medical information may be used by the person(s) I authorize to receive this information for medical treatment, consultation, billing or claims payment and for other purposes that I may direct
6. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim
7. I understand that my treatment, payment, enrollment, or eligibility benefits will not be conditioned on whether I sign this authorization
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law

Signature of Patient/Guardian: _____ Date: _____

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Targeted Case Management Needs Assessment

*Below are comprehensive needs for any medical, educational, social, mental, and other services not offered by Mile High Psychiatry. Check **ALL** that apply to receive care coordination for your needs!*

Patient Name: ***DOB:*** ***Today's Date:***

MENTAL HEALTH NEEDS	HEALTH NEEDS	ADDITIONAL NEEDS
☐ *Psychological Testing*	☐ *Primary Care*	☐ *Alcohol and Drug Abuse Treatment*
☐ *Therapy*	☐ *OBGYN*	☐ *Support Groups*
☐ *TMS*	☐ *Pain Management*	☐ *Urine Analysis:*
☐ *ECT*	☐ *Neurologist*	☐ *Other:*
☐ *IOP-Intensive Outpatient*	☐ *Neuropsych Testing*	
☐ *PHP-Partial Hospitalization*	☐ *Autism*	
☐ *Inpatient Care*	☐ *Nutritional Support*	
☐ *Residential*	☐ *Chiropractic*	

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not At all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult