Revive & Thrive
MENTAL WELLNESS

Date:							
Patient's Last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid		
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F		
Street address:		Social Security no.:		Home phone no.: ( )			
P.O. box:	City:	State:	ZIP Code:				
Occupation:	Employer:	Employer phone no: ( )					
Primary Care Provider:							

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: (		
Occupation:	Employer:	Employer address:	Employer phone no.: ( )		
Is this patient covered by insurance? ❑ Yes ❑ No					
Please indicate primary insurance ❑_____ ❑_____ ❑_____					
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other					

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance.

Patient/Guardian signature *Date*

COORDINATION OF CARE RELEASE

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: _____

Date of Birth: _____ Telephone # _____

Address: _____

RELEASE INFORMATION TO & FROM:

Pharmacy Name: _____Phone # _____

Primary Doctor: _____ Phone # _____

Counselor: _____ Phone # _____

Specialist: _____ Phone # _____

Lawyer: _____ Phone # _____

Other:_____ Phone # _____

INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

- ☐ Clinic Visit Notes
- ☐ Complete Chart
- ☐ Discharge Summary
- ☐ Imaging Reports
- ☐ Lab Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Pharmacy Reports
- ☐ Other: _____

Patient Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF SENSITIVE INFORMATION

This medical record may contain certain sensitive or statutorily protected information. Please indicate the information you would like released. A separate signature is required.

- ☐ Mental Health Information
- ☐ Domestic Violence Information
- ☐ Alcohol/Drug Abuse Information
- ☐ Social Service Information
- ☐ Sexual Assault Information
- ☐ Sexually Transmitted Diseases

Patient Signature: _____Date: _____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to **Revive and Thrive Mental Wellness.**

I also understand that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to disclosure by the recipient and no longer protected by federal laws and regulations regarding the privacy of my protected health information. I certify that I have received a copy of this authorization.

Patient Signature:_____ Witness:_____
Date:_____

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MEDICAL HISTORY

CHECK THE BOX IF YOU HAVE HAD ANY OF THE FOLLOWING:

	Diabetes		Rheumatic Fever		Heart Murmur
	High Blood Pressure		Migraines/ Headaches		Osteoporosis
	Circulatory Problems		Lung Disease		Epilepsy/ Seizures
	Arthritis		Neurological Problems		Cancer
	Stroke		Heart Disease/ Pacemaker		Fractures
	Kidney Disease		Liver Disease		Metal Implants

Other: Please explain_____

List any significant hospitalizations and surgical procedures/ reasons/ dates:

_____

_____

_____

_____

Do you have any medication allergies?

_____

_____

_____

Financial Agreement

Thank you for choosing our office for your Mental Health needs. Please read the following information and sign below.

Insurance-In Network Carriers: Revive and Thrive will submit insurance claims for **in network insurance carriers only**. Patients will be responsible for all Deductibles, Coinsurance, and Copayments at the time of service. You are responsible to make sure all of your insurance information is correct with both our office as well as the insurance company(s).
Insurance- Out of Network: Patients may request a receipt to submit to non-contracted insurance company(s). If our office does not accept your insurance, you are considered Private Pay.
Private-Pay: Patients must pay, in full, on the date of the appointment.
Payment Options: Debit or Credit Cards (Visa, MasterCard, and Discover) Flex Spending or Cash.
NO Checks will be accepted. Credit Card must be issued in the patient or guardian's name.

ADMINISTRATION FEES

These administrative fees are not billed to your insurance company as they are not reimbursable.

- Late/Canceled/rescheduled office visits less than 24 hours prior to appointment: **$25.00**
- No show for appointment: **$50.00**
  All above fees must be paid before next appointment
- Form fee: **$15.00 per form** **Must be paid before forms are given/sent to patient**
- Duplicate receipts/copies of medical records: **$0.76 per page + $.53 for postage** (If mailed via USPS)

New Patient visit: **$350.00** Follow Up **$250 Monthly/$125 Bi-weekly**

Private Pay Only

If your insurance retro terminates, you will be responsible at the Private Pay Rate

I have read the information above and acknowledge my understanding of the policy concerning financial matters.

_____ _____

Patient/Responsible Party's Signature) Date

DRUG TEST AUTHORIZATION PERMISSION FORM

I, _____, acknowledge that I have been advised that I may be required to submit to an observed urine drug screen test as part of the Treatment policy of, Revive and Thrive Mental Wellness, such drug tests are a requirement of our patient practices. I further understand that **Revive and Thrive** policy address the presence of illicit substances and or non- prescribed opioids in the systems of our patients. A confirmed positive test is a violation of this policy. Additionally, a refusal to test, failure to submit adequate urine for test, or adulterated sample, constitutes a positive test and may result in discharge.

I further understand that this analysis will be conducted by a certified laboratory with all data to be held in confidence except as otherwise necessary to carry out the terms and objectives of this policy.

I understand that it is my responsibility prior to the drug testing to inform the laboratory and/or Staff of any medication, prescribed or non-prescribed, that I may be taking and/or have taken within the last 60 days prior to the testing.

I understand that the laboratory is a third-party provider. Charges and payments are due directly to the third-party provider. Revie and Thrive will supply demographics and insurance information to the lab provider for billing purposes with permission per signing this form.

I consent to the release of the results of any drug test to authorized representatives of the **Revive and Thrive** medical practice for appropriate review.

I consent freely and voluntarily to a drug test under the circumstances described above along with all the terms and conditions of the Patient Treatment Policy. I also understand that although I may not agree with the Drug Screening Consent, failure to acknowledge the policy with my signature below may prohibit my treatment with **Revive and Thrive** and can result with an immediate discharge from the practice. A photocopy of this authorization shall be deemed an original and shall be accepted as such by every person.

_____ _____
Patient's Full Printed Name Date

_____ _____
Patient's Signature Date

_____ _____
Provider Signature Date

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____
(Name of Client) (Date Of Birth)

authorize Revive and Thrive Mental Wellness, DISCLOSE TO/OBTAIN FROM

Maryland Medical Assistance Program or Medicaid (Optum and all MCOS), Mental Health Management Agency (MHMA) and Local Addiction Authority (LAA), Outpatient Centers, Medication Assisted Treatment Physicians, and Any Physician listed as a CURRENT PRESCRIBER under my personal information

I understand that my records are protected under the Federal regulations governing Confidentiality of Mental Health Records, 42 C.F.R. Part 2, and that any information that identifies me as a patient in an Mental Health program cannot be disclosed without my written consent except in limited circumstances as provided for in these regulations.

I understand that my records are also currently protected under the Federal privacy regulations within the Health Insurance Portability and Accountability Act (HIPAA), 45 C.F.R. Parts 160 & 164. I understand that my health information specified above will be disclosed pursuant to this authorization, and that the recipient of the information may re-disclose the information and it may no longer be protected by the HIPAA privacy law. The Federal regulations governing Confidentiality of Mental Health Records, 42 C.F.R. Part 2, noted above, however, will continue to protect the confidentiality of information that identifies me as a patient in a Mental Health program from re-disclosure.

I understand that the covered entity seeking this authorization is not conditioning treatment, payment, enrollment, or eligibility for benefits on whether I sign the authorization.

I also understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this authorization expires automatically one year minus a day from the date that it is signed.

_____ _____
Signature of Client Date

_____ _____
Signature of Witness Date

Revive & Thrive
MENTAL WELLNESS

Revive and Thrive Mental Wellness strives to treat Clients with consideration, respect and full recognition of their human dignity and individuality. Additionally, the Program does not discriminate in the provision of services based on race, creed, color, age, gender, sexual orientation, national origin, marital status, disabilities, and other classification prohibited under State and Federal law including The American with Disabilities Act, 28 CFR 35, and The Fair Housing Act, 42 USC 3604.

By initialing and signing below, I, the undersigned, do hereby state that I:

_____ 1. Have received the client handbook

_____ 2. Have received a copy of, read and understand the Program Rules, Clients' Rights and Clients' Grievance Policy of Revive and Thrive and agree to comply with the Program's rules Policies and Procedures

_____ 3. Understand I have the right to file a grievance towards program decisions regarding my care and/or any incidents of unfair, discriminatory, or unethical treatment

_____ 4. Understand that it is my responsibility to take medication as prescribed

_____ 5. I understand that I need to remain free from obsessive use of alcohol/ illicit substances while receiving treatment at Open Arms. I further understand that if I do not remain free from obsessive illicit substances/alcohol use while in this program, my treatment status will be reviewed, and I will be referred to an appropriate level of care.

___6. I agree to disclose any alcohol and/or drug use while receiving treatment at Revive and Thrive Mental Wellness. I understand that I may be asked to participate in urine screenings and breathalyzer monitoring and may be responsible for payment of associated fees in advance.

_____ 6. Understand upon request I can receive a list of community resources, including medical, vocational, mental health, legal, and social services.

_____ 7. Have been made aware of the fees for services

_____ 8. Consent to treatment at Revive and Thrive Mental Wellness.

_____
Client's Name

_____ _____
Signature of Client Date

_____ _____
Signature of Clinician Date