Lighthouse Mental Health Group, PLLC.

Patient Demographics

Date ____ /____ /_____

Last Name: _____ First Name: _____ MI: ___ ☐Male ☐Female

Date of Birth: _____ Age: _____ Marital Status: Single☐ Married☐ Divorced☐

Occupation: _____ SSN: _____

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone (Optional): _____

E-mail: _____

Preferred Method of Contact– ☐-Home ☐-Cell ☐-Work – **May we contact you at work? Yes** ☐ **No** ☐

Emergency Contact: _____ Relation: _____

Phone: _____

Primary Care Physician: _____ Phone: _____

Address: _____

Referred by: _____ Phone: _____

PARENT/GUARDIAN/RESPONSIBLE PARTY ☐SELF ☐ OTHER (Please complete if other)

Last Name: _____ First Name: _____ MI: ____ Suffix: ____ ☐Male ☐Female

Home Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Position/Title: _____

INSURANCE INFORMATION

PRIMARY Insurance Company: _____

Policy ID#: _____ Group#: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Relationship to patient: _____

SECONDARY Insurance Company: _____

Policy ID#: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

Lighthouse Mental Health Group, PLLC.

Release of Protected Health Information

Patient Name: _____ Date of Birth: ____/____/_____

I grant permission for my healthcare provider and the representatives of Lighthouse Mental Health Group to discuss my care using this disclosure form to share information about my healthcare or discuss financial information for payment on my account.

I authorize the release of my protected health information to the following person(s)/ entity:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

The information you wish to share is listed below. Please check all that apply.

Appointment information ____
Explanation of diagnosis/ treatment plan ____
Laboratory Reports ____
Billing Inquiries ____
Other ____
I do not wish to share my information with anyone. ____

I authorize the following additional communication methods for Lighthouse Mental Health Group to communicate information to me about the status of my care:

Email me about my protected health information: Yes ☐ No ☐

Leaving a voicemail regarding lab care or facility services: Yes ☐ No ☐

Mailing Statements/Letters to my Residence on file: Yes ☐ No ☐

I understand that my healthcare information at Lighthouse Mental Health Group is protected. By signing this form, I am granting Lighthouse Mental Health Group to disclose my protected health information for the purpose of treatment, payment and health care operations. Lighthouse Mental Health Group Notice of Privacy Practices provides more detailed information about how we may use and disclose this information. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office. If you would Like a copy of our Notice of Privacy Practices, please see the front desk staff.

Patient or Authorized Legal Representative Signature _____

7434 Louis Pasteur, Suite 220 San Antonio Tx, 78229 • info@lighthousesa.health • Fax: 210.888.1449

Lighthouse Mental Health Group, PLLC.

Financial & Office Policies – Consent to Treat

Thank you for choosing Lighthouse Mental Health Group. We are dedicated to providing the best care possible. Our staff will be happy to discuss this policy with you at any time. ***We ask that you read and sign these policies on page 2.***

Payment for services is due at the time of service. This may include co-pays, unpaid balances, deductibles; copayments and fees are due at the time of your visit. We accept cash, debit, and all major credit cards.

1. **ASSIGNMENT OF BENEFITS: I** hereby authorize my insurance benefits to be paid directly to Lighthouse Mental Health Group and understand that I am financially responsible for all co-pays, deductible amounts, and non-covered services. I also authorize Lighthouse Mental Health Group to release any information to my insurance company needed to process claims.

2. **CONSENT TO TREATMENT: I** authorize and request my provider to carry out evaluations and treatment plans for myself or my legal ward. Paperwork will be needed for any guardianship. I understand that the plan will be explained and is subject to my agreement.

3. **APPOINTMENTS**: Please arrive on time for your appointments. We may need to reschedule the appointment if you arrive after the appointment time. **New Patients:** We require a reservation fee of $100 to schedule your first appointment. If you have in-network insurance, this fee may be refunded to you at your first appointment (depending on your insurance plan/coverage); you will then be charged for your visit in accordance with your insurance plan/coverage. For Cash/selfpay patients (including those with out-of-network insurance), the registration fee is applied to your New Patient appointment and the remaining balance is due at the time of your visit. **ALL New Patient Paperwork and measures must be completed and sent to our office three business days prior to appointment. If this is not received promptly, your appointment will be rescheduled.**

4. **PATIENT PORTAL – MEASURES: All patients must have an active Patient Portal.** The patient portal is the preferred place to sign the New Patient Paperwork (Esign) as well as to complete clinical follow forms for your provider which are called measures. The measures are to be completed before each follow up appointment and typically are sent to your patient portal 2 days prior to your appointment where you are notified via email.

5. **MISSED/CANCELLED APPOINTMENTS**: For **NEW PATIENTS:** we ask that you cancel your first appointment no later than **3** business days before your scheduled appointment by speaking to a staff member. Late cancellation of your appointment will result in your $100 reservation fee not being refunded. **ESTABLISHED PATIENTS**: patients are asked to cancel at least 24 hours in advance of the scheduled appointment time. There will be a **$50 late cancellation charge** if you do not cancel your appointment within that time limit. You will be charged a **$100 No-Show Fee** if you do not show to your appointment. This charge is not payable by insurance, and I understand that this will be my responsibility.

6. **TELEMEDICINE POLICY**: We offer Telemedicine/Telehealth appointments after your initial appointment. Telemedicine services involve the use of secure videoconferencing equipment and devices that enable health care providers to deliver health care services to patients. We require a once a year in-office visit.

7. **CHANGE OF INFORMATION:** Please provide us with any change of your address, phone number or insurance information as soon as possible.

8. **MEDICATION REFILLS**: **Please contact our office.** ***You must be seen regularly (usually not less than every 3 months) for proper monitoring of your condition and the medications prescribed. Medication*** will not be filled after hours or weekends. A charge of $20 will be applied to prescriptions that are written between appointments.

9. **URINE PRESCRIPTION MONITORING:** Urine prescription monitoring will be conducted on all new patients and periodically on patients taking controlled substances. Patients with drug screens positive for illicit substances will not continue controlled medications.

10. **MEDICAL RECORDS:** To request copies of your medical record, a release of information form must be signed. Your request will be fulfilled within 15 business days upon receipt of the medical release form. Fees: Per rules adopted by the Texas State Board of Medical Examiners: $25.00 for the first 20 pages, $.50 cents for each page thereafter. No charge Doctor to Doctor/Hospital. Charges will be assessed for Letters and completion of forms.

11. **AFTER HOURS CARE:** In a life-threatening emergency, please call 911. For urgent non-emergency matters please call our office number (210)-714-0066 and leave a message with the answering service. If needed the provider on call will return your call as soon as possible.

12. **TERMINATION OF DOCTOR/PATIENT RELATIONSHIP:** The provider reserves the right to terminate the doctor/patient relationship at their discretion. Reasons for termination may include but are not limited to failure to follow treatment plan, untimely unpaid balances, history of missed appointments, tampering or refusal of drug screen, verbal abuse of staff and lack of good fit. The patient (or the patient's legal representative) has the right to terminate treatment at his/her discretion. Upon either party's decision to terminate the relationship, the provider will continue emergency care for at least 30 days and recommend more appropriate resources.

13. **LEGAL AND COURT-RELATED MATTERS:** Dr. Deeves and the providers with Lighthouse Mental Health Group do not take part in court-related matters, such as divorce or child support cases. However, if court-related work is needed, the practices' cost related to that work is the sole responsibility of the patient and/or their responsible party. These matters include but are not limited to preparation, communication with involved parties, depositions, testimony, standby efforts, attorney fees, and other costs incurred as a direct result of the matter.

14. **EDUCATION:** Lighthouse Mental Health Group is a teaching site for the University of Texas Health Science Center at SA (UTHSCSA). You may be asked to allow students to join your session. The choice is entirely yours. We appreciate your contribution to their medical education.

15. **COLLECTION AGENCY:** In the event of a delinquent account balance, I will be responsible for all collection fees assessed by the collection agency onto the account.

I have read and agree to the above policies and terms regarding payment and payment responsibilities.

Patient Name | Patient or Authorized Representative Signature | Date