best day
PSYCHIATRY AND COUNSELING, PC

OFFICE POLICY

Please familiarize yourself with our office polices.
If you have any questions, please call our office and let us know immediately.

INSURANCE:

1. Patients are responsible for being aware of current insurance coverage. This includes details of
    a. Out of network benefits
    b. Deductible and/or "out of pocket"
    c. Current coverage and co-payment/co-insurance
    d. Maximum annual visits
    e. Current visit remaining
    f. Any changes in coverage

2. If you have exceeded your benefits covered **YOU** are responsible for the **full payment** for any uncovered sessions.
3. Please note that your insurance may place limits on the number of visits allowed per calendar year. This may not be sufficient to cover the clinically appropriate level of care determined by your doctor.
4. If insurance information is not given with 30 days, we will not be able to bill and/or your sessions may not be paid
5. If a change in insurance has not been given to Best Day Psychiatry and Counseling, you will be responsible for your sessions

MEDICATIONS:

1. To ensure quality of care, **regular follow up** with routine office visits is necessary for prescriptions to be provided.
2. If 2 or more scheduled office visits have been missed, or the time since the last appointment exceeds 90 days, the physician **must be seen** before any prescriptions are written.
3. Please inform your physician about needed refills at least **3 business days** before your medication runs out.
4. **Prescriptions that are lost, misplaced, stolen, destroyed, or finished early will not be replaced for any reason**.
5. You must **NOT** share, sell, or otherwise permit others to have access to your medications

Cancellations/Missed Appointments:

1. Because your appointment time has been reserved for you, **you will be charged for cancellations with less than 24 hours (one business day) notice.**
2. Charges for late cancellations/ missed appointments are **not covered** by your insurance company and are due and payable prior to any further appointments. **Please note that such charges include the amount normally covered by the insurance company in addition to the copay amount**.

Payments:

1. Payment is expected at the time of appointment. We accept cash, checks, visa, or MasterCard
2. There is a $25 charge for **ALL** returned checks.

Medical Records:

Please allow at least 7 days to receive medical records**.**

Urgent Services:

In the event urgent services are needed, you will be scheduled to see a provider within 48 hours. Communication with provider will determine the urgency of the situation and what the plan of care will include.

OFFICE POLICY PATIENT ACKNOWLEDGMENT

PATIENT NAME:_____ **DOB:**_____

Signature:_____ **Date:**_____

RELATIONSHIP TO PATIENT IF MINOR:_____

Proudly serving Fayetteville, Fuquay-Varina, Raleigh, Greenville, Durham, Wilmington, Greensboro, Winston-Salem & Charlotte

REGISTRATION FORM

PATIENT INFORMATION

Patient's last name: First: Middle: Parent/Guardian name:			☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐ Race: _____	
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 # ()	Cell Phone no# ()	
P.O. box:	City:	State:		ZIP Code:		
Occupation:	Employer:	Employer phone no.: ()				
Email Address: _____	Highest Level of Education: _____					
Primary Care Provider:	Address:	Phone:				

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Person responsible for bill: (Parent or Guardian-not insurance)	Birth date:	Address (if different):	Home phone no.: ()	
Is this person a patient here? ☐ Yes ☐ No				
Occupation:	Employer:	Employer address:	Employer phone no.: ()	
Is this patient covered by insurance? ☐ Yes ☐ No				
Name of Primary insurance :	Subscriber's name:		Subscriber's SSN #.:	Group no.:
			Subscriber's D.O.B.	Policy no.:
Name of Secondary insurance:	Subscriber's name:		Subscriber's SSN#.:	Group no.:
			Subscriber's D.O.B.	Policy no.:

Proudly serving Fayetteville, Fuquay-Varina, Raleigh, Greenville, Durham, Wilmington, Greensboro, Winston-Salem & Charlotte

CONSENT TO DISCLOSE PATIENT HEALTH INFORMATION TO FAMILY AND FRIENDS INVOLVED IN PATIENT CARE

Patient Name: _____

I understand that Best Day Psychiatry and Counseling may disclose my protected health information to a family member, relative, friend or other person that I identify who is directly involved in my care, or payment of my care, provided that I have an opportunity to agree to, or object to, such disclosure.

Therefore, I hereby consent, agree, and authorize Best Day Psychiatry and Counseling to disclose my protected health information to the following individual(s) who is or are directly involved in my care, or in the payment of my care:

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

Name/ Relationship: _____ _____
Allowed to bring patient to appointments☐ Yes ☐ No

I understand that by consenting to the disclosure of my protected health information to the individual(s) identified above, all my personal information relevant to my care and treatment may be disclosed, including but not limited to, my medical history, my medical condition, diagnostic tests performed, laboratory results, prescriptions, surgical procedures, and other personal information given to,or discussed with Best Day Psychiatry and Counseling.

Please note, that **ONLY** the patient can pick up prescriptions that are controlled substances. For patients under the age of 18: **ONLY** the parent/guardian can pick up prescriptions that are controlled substances.

This consent to disclose my protected health information applies to:

☐ This visit only: Date:_____

☐ All visits at which the individual(s) identified is or are present

☐ All communications with the individual(s) identified above, including information provided in person, by telephone, or by mail.

This consent is immediately effective and shall remain effective for 365 days. I understand that I have the right to revoke this consent at any time by providing written notice to Best Day Psychiatry and Counseling. I understand that I am not required to sign this form in order to receive treatment, and that I am voluntarily requesting and consenting to Best Day Psychiatry and Counseling disclosure of my protected health information to the individuals identified above.

Patient/Parent/Guardian Signature: _____ Date: _____

CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

I understand that as a patient of **Best Day Psychiatry and Counseling** I may be eligible to receive all services that are offered**.** The goal of the assessment process is to determine the best course of treatment for me. I understand that all information shared with the clinicians at **Best Day Psychiatry and Counseling** is confidential and no information will be released without my consent. During the course of treatment at **Best Day Psychiatry and Counseling**, it may be necessary for my provider to communicate with other providers at **Best Day Psychiatry and Counseling.** While written authorization will not be requested, prior to any discussions with another **Best Day Psychiatry and Counseling** provider, I understand that in all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:
A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

In a medical or health emergency, I authorize the agency to administer first aid as needed and contact:

Name	Relationship	Telephone Number
Name	Relationship	Telephone Number

Additionally, in an emergency, a voluntarily admitted consumer may be administered treatment or medication, despite the consumer or the legally responsible person's refusal, even if the consumer's refusal is expressed in a valid advanced written instruction.

I choose the following hospital, medical doctor, and dentist to provide services to me:

Hospital Preference	Address	Phone Number
Medical Doctor	Address	Phone Number
Dentist	Address	Phone Number

If the above medical doctor or dentist cannot be reached, I give my permission to be seen and treated by a licensed physician or dentist or I may be taken to the nearest emergency room by ambulance if necessary. I will not hold this provider/agency accountable for these expenses.

If I have any questions regarding this consent form or about the services offered at **Best Day Psychiatry and Counseling,** I may discuss them with my provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by **Best Day Psychiatry and Counseling**. I understand that I may stop treatment at any time.

Consumer or Legally Responsible Person Signature	Relationship to Consumer	Date
Witness Signature		Date

Proudly serving Fayetteville, Fuquay-Varina, Raleigh, Greenville, Durham, Wilmington, Greensboro, Winston-Salem & Charlotte

Signature on File for Insurance

I,_____(print your name) provide this signature as authorization for payment of all my medical services to Best Day Psychiatry and Counseling of:

Best Day Psychiatry and Counseling of Fayetteville	2587 Ravenhill Drive, Fayetteville, NC 28303
Best Day Psychiatry and Counseling of Fuquay-Varina	609 Attain Street Unit 101, Fuquay-Varina, NC 27526
Best Day Psychiatry and Counseling of Raleigh	4505 Fair Meadows Lane Suite 102, Raleigh, NC 27607
Best Day Psychiatry and Counseling of Greenville	1510 East Arlington Blvd Suite B, Greenville, NC 27858
Best Day Psychiatry and Counseling of Durham	4905 Pine Cone Drive Suite 9, Durham, NC 27707
Best Day Psychiatry and Counseling of Wilmington	2601 Iron Gate Drive Suite 204, Wilmington, NC 28412
Best Day Psychiatry and Counseling of Charlotte	5950 Fariview Road Suite 808, Charlotte, NC 28210
Best Day Psychiatry and Counseling of Winston-Salem	150 Kimel Drive Suite 100, Winston-Salem, NC 27103
Best Day Psychiatry and Counseling of Greensboro	2309 West Cone Blvd Suite 110, Greensboro, NC 27408

I understand that if my services are not covered by my insurance it will become solely my (the patient's/parent/guardian) responsibility.

_____

Signature of Consumer or Legally Responsible Person

_____

Date

Proudly serving Fayetteville, Fuquay-Varina, Raleigh, Greenville, Durham, Wilmington, Greensboro, Winston-Salem & Charlotte

AUTHORIZATIONS

ALL RECIPIENTS

Patient Name: _____

I have been informed that it is my responsibility to verify coverage of the mental health benefits with my insurance company prior to receiving treatment at **Best Day Psychiatry and Counseling**

Best Day Psychiatry and Counseling verifies authorizations with insurance companies as a courtesy. Authorization is not a guarantee of payment. I understand that any charges not covered by my insurance company will become my responsibility.

Family therapy appointments without the patient present, is not a covered charge. Such services are the responsibility of the Patient.

Patient/Parent/ Guardian Signature:_____ Date_____
Guardian Description:_____
Witness:_____ Date_____

* MEDICAID RECIPIENTS ONLY *

Patient Name: _____

I have been informed that Medicaid will only pay for 3 initial mental health evaluations in a twelve month period. I understand that if at any time my Medicaid becomes inactive I will be responsible for the payment of the corresponding dates of service.

Patient/Parent/ Guardian Signature:_____ Date_____
Guardian Description:_____
Witness:_____ Date_____