Lansing Institute of Behavioral Medicine

3475 Belle Chase Way
Lansing, MI 48911
Phone: (517)882-3732 Fax: (517)882-3633

PATIENT NAME: _____ **DATE OF BIRTH**: _____

PHONE NUMBER(S): _____

IS THE PRACTICE AUTHORIZED TO LEAVE **DETAILED** VOICEMAILS ON THE NUMBER(S) PROVIDED ABOVE? YES NO

SS#: _____ **EMPLOYER**: _____

SEX: Female ☐ Male ☐ **MARITAL STATUS**: Single ☐ Married ☐ Divorced ☐

REFERRING DOCTOR: _____ **PRIMARY CARE DOCTOR:** _____

RESIDENTIAL AND CORRESPONDENCE MAILING ADDRESS:

ADDRESS _____

CITY: _____ STATE: _____ ZIP: _____

BILLING ADDRESS (IF DIFFERENT THAN THE ABOVE):

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE #1: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

HOLDER DOB: _____ INSURED SS#: _____

INSURANCE #2: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

HOLDER DOB: _____ INSURED SS#: _____

PARENT OR LEGAL GUARDIAN: **(IF PATIENT UNDER THE AGE OF 18 OR GUARDIANSHIP ESTABILSHED BY COURTS)**

NAME: _____ DATE OF BIRTH: _____

PHONE: _____ TYPE OF GUARDIANSHIP: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

INSURANCE INFORMATION (PLEASE PRESENT INSURANCE CARD FOR PHOTOCOPY) In order to submit a claim for payment, for services covered under your policy, we require authorization to release medical information to our billing company. I authorize the release of any medical information necessary to process my medical service claims. I permit a copy of this authorization to be used in place of the original. I hereby authorized Lansing Institute of Behavioral Medicine and its associated billing company to file for benefits on my behalf for any and all medical services rendered. Insurance claim and patient payments shall be made directly payable to Lansing Institute of Behavioral Medicine. If I have Medicare insurance, I authorize Lansing Institute of Behavioral Medicine and its associated billing company to release to the Social Security and Care Financing Administration or its intermediaries or carriers any information needed for a related Medicare claim. I certify that I am financially responsible for all services not paid by insurance. I hereby authorize Lansing Institute of Behavioral Medicine to provide the following treatment; Psychiatric Evaluation, Psychotherapy and Medication Evaluation/Treatment. These authorizations are valid indefinitely until revoked in writing by myself or by Lansing Institute of Behavioral Medicine.

SIGNATURE _____ DATE _____

Yearly Information Signoff:

Sign_____ Date_____ STAFF WITNESS_____ DATE_____

Sign_____ Date_____ Sign_____ Date_____

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As a patient of Lansing Institute of Behavioral Medicine, I understand that it is my responsibility to know and understand policies and benefits of my insurance plan. These include but not limited to:

1. Resulting co-payments, deductibles and outstanding balances to be paid at the time of service.
2. Any required referrals and authorizations
3. Outpatient/inpatient, hospital, laboratory, x-ray, homecare, and pharmacy benefits.
5. Updated demographic information provided prior to time of service.

Please note failure to provide correct/updated insurance information will result in patient being billed for services.

No Show/Late Cancellation (less than 24 hours)	$75-$125
Forms/Letters/Treatment Summaries (Requested by the patient)	$25-50
Prescription Refills (those not given by the provider at a scheduled appointment)	$10
Neurological Testing No Show	$250

As a Patient of Lansing Institute of Behavioral Medicine, I have been informed that in the event of a missed or cancelled appointment without a minimum of 24-hour notice, that I will be charged for the missed appointment according to the rate schedule above.

The rates scheduled above are not covered by my insurance company and I understand and agree that these charges are my responsibility to pay before my next scheduled appointment. If you have any balances you will not be allowed to schedule your next appointment until payment is received in full. I agree and understand that there are no exceptions to the scheduled fees unless previous arrangements are requested and approved by practice management.

Patient's Full Name:_____

Signature: _____ Date: _____

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CONFIDENTIAL COMMUNICATIONS AUTHORIZATION

EMERGENCY CONTACT

NAME: _____RELATIONSHIP: _____

PHONE NUMBER(S): _____

Is the practice authorized to leave detailed voicemails on the number(s) provided above? Yes No

I authorize the release of my protected health information over the telephone or in-person to my listed emergency contact above:

Yes No

I authorize the release of my protected health information over the telephone or in-person to the following individuals:

Name: _____ Relationship: _____

Phone Number: _____ May the practice release billing information to this person? Yes No

Name: _____ Relationship: _____

Phone Number: _____ May the practice release billing information to this person? Yes No

Name: _____ Relationship: _____

Phone Number: _____ May the practice release billing information to this person? Yes No

Name: _____ Relationship: _____

Phone Number: _____ May the practice release billing information to this person? Yes No

Is the practice authorized to leave **detailed** voicemails on the number(s) provided above? Yes No

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Patient Signature: _____ Date: _____

Witness Signature: _____Date: _____

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Courtesy Appointment Reminders

Lansing Institute of Behavioral Medicine can provide appointment reminders to our patients 3 days before their scheduled appointment. These confirmations will be provided via text or email. Please indicate your confirmation preference below:

- I would like to receive my courtesy reminders via text message via this cell phone number:

Cell Phone Number: _____

- I would like to receive my courtesy reminders via this email.

Email: _____

- I request no courtesy confirmations from Lansing Institute of Behavioral Medicine. I understand that if I miss my appointment without providing 24-hour notice, I will be charged for the missed appointment in accordance with office policy.

*Please note that these reminders are a courtesy, the patient is still responsible for timely attendance of their appointment without a reminder.

Signature: _____

Printed Name: _____

Date: _____

Release of Information
Authorization for Disclosure of Mental Health Treatment Information
Primary Care Physician

_____ Check here to decline authorizing release medical information to a therapist

Patient Name: _____ DOB: _____ Phone: _____

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION BETWEEN BOTH PARTIES INDICATED BELOW:

FROM:

_____
(Provider Name)

Lansing Institute of Behavioral Medicine
3475 Belle Chase Way
Lansing, MI 48911
Phone: 517-882-3732
Fax: 517-882-3633

TO:

_____
(Primary Care Physician/Practice)

_____
Address

_____
City, State, Zip Code

_____
Phone

_____
Fax

Description of Information to be Disclosed--Initial those that apply, will be disclosed upon request from above party

____ Diagnosis Only ____ Medication Information Only ____ Treatment Summary ____ Medical Records

Purpose
Coordination of Care between Primary Care Provider and Mental Health Provider

Conditions
A request for disclosure of health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
I understand that my records are protected under the applicable state law governing health care information and that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records 42 CRF Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.
I further understand that Lansing Institute of Behavioral Medicine will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization will result in Lansing Institute of Behavioral Medicine not being permitted to release/disclose any of my information.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Medical Records Department at Lansing Institute of Behavioral Medicine at the address above. I further understand that revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed be the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration
Unless sooner revoked, this authorization expires **1 year** from the date of signature or as otherwise indicated here: _____.

I have the right to be given a copy of this authorization for my records.

_____ _____
Signature of Patient/Client Date Signature of Parent, Guardian, or Personal Representative Date

If you are signing as the personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc

Lansing Institute of Behavioral Medicine

Release of Information
Authorization for Disclosure of Mental Health Treatment Information
Therapist

Patient Name: _____ DOB: _____ Phone: _____

_____ Check here to decline authorizing release medical information to a therapist

I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION BETWEEN BOTH PARTIES INDICATED BELOW:

FROM:

_____
(Provider Name)

Lansing Institute of Behavioral Medicine
3475 Belle Chase Way
Lansing, MI 48911
Phone: 517-882-3732
Fax: 517-882-3633

TO:

_____
(Therapist)

_____
Address

_____
City, State, Zip Code

_____
Phone

_____
Fax

Description of Information to be Disclosed--Initial those that apply, will be disclosed upon request from above party

___ Psychotherapy Notes

Purpose
Coordination of Care between Therapist and Mental Health Provider

Conditions
A request for disclosure of health information may include information regarding drug, alcohol or mental health treatment, social service records, communications made to a social worker and information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code, which includes venereal disease, tuberculosis, acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).
I understand that my records are protected under the applicable state law governing health care information and that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patients Records 42 CRF Part 2 and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations.
I further understand that Lansing Institute of Behavioral Medicine will not condition my treatment, payment, enrollment, or eligibility for benefits on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization will result in Lansing Institute of Behavioral Medicine not being permitted to release/disclose any of my information.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Medical Records Department at Lansing Institute of Behavioral Medicine at the address above. I further understand that revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Form of Disclosure
Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Re-disclosure
I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed be the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

Expiration
Unless sooner revoked, this authorization expires **1 year** from the date of signature or as otherwise indicated here: _____.

I have the right to be given a copy of this authorization for my records.

_____ _____
Signature of Patient/Client Date Signature of Parent, Guardian, or Personal Representative Date

If you are signing as the personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc

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ACKNOWLEDGEMENT/RECEIPT OF NOTICE OF PRIVACY PRACTICES & POLICIES

I have been given the option to read/received a copy of the "Notice of Privacy Practices & Policies" upon request at the reception desk. This notice describes how we protect the health information we have about you which relates to your services from Lansing Institute of Behavioral Medicine and how we may use and disclose this information. This notice also describes your rights with respect to your protected health information and how you can exercise and access those rights.

We are required to provide this notice to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

_____ _____

Patient's Full Name Guardian/Parent Name

_____ _____

Patient/Guardian/Parent Signature Date

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MARIJUANA INTERACTION WITH OTHER DRUGS

LEGAL DISCLAIMER AND ACKNOWLEDGEMENT

Your physician's recommended course of treatment may include one or more prescription or nonprescription drugs. It is your responsibility to fully inform your physician of all other prescription and nonprescription drugs that you are taking. Only with this information will your physician be able to properly advise you regarding adverse effects resulting from their interactions and make necessary adjustments to these drugs and their dosage that may need to be made.

You must inform your physician if you use marijuana (along with the frequency and amounts of your usage). Unlike prescription drugs, there is very little research available on (and limited reliable studies) the effects of the interaction of marijuana and prescription drugs. Due to the lack of studies/research your physician cannot predict what, if any, effects there will be resulting from using marijuana with the prescription and nonprescription drugs that are to be used during the course of your treatment.

Your physician disclaims any obligation to inform you the possible effects of the interaction of marijuana and the prescription and nonprescription drugs that are to be used during the course of your treatment unless you have first disclosed to your physician that you are using marijuana and have accurately disclosed the frequency and amounts.

Whether you have made full disclosure of your marijuana use or not, your physician disclaims any obligation to describe to you the effects of the interaction of marijuana and the prescription and nonprescription drugs to be used during the course of your treatment due to the lack of reliable research and/or studies on this topic. You agree to hold harmless your physician for any negative outcome while you take prescriptions in conjunction with marijuana.

By signing below, you acknowledge that if you choose to use marijuana with prescription and nonprescription drugs that are to be used during the course of your treatment is solely at your own risk.

*By signing this document, you are acknowledging the policy. This is not an admittance of use.

_____	_____
Patient Signature	Witness Signature
_____	_____
Print Name	Print Name
_____	_____
Date	Date

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LANSING INSTITUTE OF BEHAVIORAL MEDICINE
Patient Care and Treatment Contract
Regarding Controlled Medications

The purpose of this contract is to maintain a safe and effective treatment plan of care for patients who are prescribed and using controlled medications as part of their medication regimen. Due to very high incidence of controlled medication use, misuse, dependence and abuse that is being reported in communities all over the country, the FDA and the state of Michigan have established new treatment guidelines that require increases safety measures and patient information education from prescribers of controlled medications; increased monitoring of controlled medication use by patients and increased accountability of both providers and patients through established monitoring strategies.

Controlled medications that fall under this monitoring contract include:

- Sedative/Hypnotics (most sleeping medications)
- Anxiolytics/Benzodiazepines (such as Xanax, Ativan, Klonopin, Valium and others)
- Opioid pain medications
- Stimulant medications (Ritalin and Adderall in all of their forms)

All patients who are taking or are prescribed any of the medications that are controlled must agree to the terms established below in order to continue care and treatment here at LIOBM.
Please read each item carefully and then sign your agreement at the end of the form.

- ❖ Failure to sign the agreement will result in the discontinuation of further prescription refills for these medications.
- ❖ Failure to adhere to the signed agreement may result in immediate treatment termination and discharge from our care.

1. I agree/understand that before my provider issues any prescriptions for a controlled substance he/she will review a Michigan Automated Prescription (MAPS) report to verify that I am not receiving similar controlled medications from any other provider.

2. I agree/understand that I must choose one pharmacy for all controlled medication prescription refills. And that I will not ask for or accept any similar controlled medication prescriptions from ANY other provider while receiving care with an LIOBM provider.

Designated Pharmacy: _____ Phone #_____

LANSING INSTITUTE OF BEHAVIORAL MEDICINE
Patient Care and Treatment Contract
Regarding Controlled Medications (Continued)

3. I agree to follow the treatment guidelines set for me with my medication as directed and to not alter the dosing or frequency of controlled medication use without consulting first with my LIOBM provider.
   I understand that taking more medication than prescribed can result in very dangerous outcomes including over sedation, accidental overdose, organ damage, coma or death.
   I also understand that if I over use or run out of my medications early or stop taking them suddenly, I could have uncomfortable and possibly dangerous withdrawal symptoms.
   For women - I understand that if I should become pregnant, there are some known and unknown risks to an unborn child. Pregnancy and medication issues must be discussed with my LIOBM provider.

4. I agree/understand that at the discretion of my LIOBM provider and at least once per year, I will be asked to provide body fluid testing for a random drug test at the office or lab. Failure to comply with the testing will result in discontinuation of controlled medication treatment.

5. I understand the potential risks and side effects of taking the medication prescribed to me.
   I understand that drinking alcohol, using opioid pain medications and or using marijuana while on my medications can have serious adverse consequences and can be very dangerous. I should not combine any of these things with my meds.

6. I agree/understand that controlled medication prescriptions can only be given to me at my scheduled office visits.
   A missed visit may result in not being able to get a prescription until the next scheduled appointment.

7. On-Call/After hours providers from LIOBM are not able to refill controlled substance prescriptions (including sleeping meds and anxiety meds) on evenings, weekends or holidays. Upon verifying a drug/dose with the established pharmacy, the On-Call provider may release just a dose or 2 to get the patient to the next business day to seek a regular refill. But this is at the discretion of the On-Call provider. There will be a prescription call in fee and the cost of the medication is the responsibility of the patient. Stimulant medications are NEVER ordered/refilled via the On-Call service.

8. I agree not to sell, share or give away any of my medication to another person. I will keep my medications in a safe and secure place and out of reach of children or unauthorized others.
   Lost, misplaced or stolen medications/prescriptions will not be replaced regardless of the reason.

9. I agree/understand that altering a prescription or medication order in any way is a serious offence that will result in immediate discharge from care with your LIOBM provider and may result in criminal charges.

Patient Acceptance Signature: _____ Date: _____

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IMPORTANT OFFICE INFORMATION FOR PATIENTS

Reception Desk/Scheduling:

If the Front Staff is unable to answer your call, please leave a detailed message on the Voicemail. The Front Staff clears and returns calls continuously throughout the day **8am to 5pm** weekdays, you will receive a call back before the end of the day if calling during this time. Any messages left after 5pm will be returned the next day.

Medication Refills/Nursing Line:

- To contact the Nursing Staff please leave a detailed message on the Nurse Line Voicemail at 517-882-3732 following the prompts to Nursing Line. The Nurse Line is NOT answered live due to the high volume of calls. All messages are cleared between **9am and 3pm** weekdays and messages received after 3pm will be addressed the next business day.
- When requesting a refill please leave the following information to leave on the voicemail: Patient Name with spelling and phone number, medication name with spelling and dosage, pharmacy name and phone number. If all information is NOT included in the voicemail message your refill could be delayed.
- All medication refills will be processed within 72 hours. Same day refills and lost prescriptions may require a $10.00 fee, which is due at your next office visit.
- LIOBM does not respond to refill requests from pharmacies, local or mail order. The patient must initiate the medication refill process.
- LIOBM does not E-scribe or fax prescription. We also cannot call prescriptions in to mail order pharmacies.
- Prior Authorizations can take several days to complete. Calling the office 1 week prior to your refill date can prevent running out of a prescription while waiting for an insurances decision.
- LIOBM is unable to take "walk-ins" and all refill requests need to go through the Nurse Line Voicemail.
- Any prescription pick-ups MUST BE between 9am and 3pm unless other arrangements have been made with Nursing Staff.
-

Insurance Notice:

-Please note Lansing Institute of Behavioral Medicine is NOT contracted with Beacon Health (Value Options), Priority Health HMO, or Magellan.
-We do not bill for services rendered to Priority Heath HMO or Beacon Health (Value Options), patient is responsible for services payment.
-Magellan plans may have an Out-of-Network option where Magellan can be billed for up to 50% of the cost of services. Patient will be responsible for the remainder, this is collected at time of service.
-If you do not have insurance, or you have a plan that we do not accept, payment is due at time of service.

Patient is responsible for contacting their insurance to verify the mental health coverage under their plan AND for informing our office of any insurance changes prior to time of service. Failure to do so may result in unexpected bills which the patient will be responsible for.

-Any questions regarding insurance or billing should be directed to 517-882-3732 following prompts to Billing.