Patient Registration Form

Patient Information:

____ Male ____ Female Other:_____ ____ Single ____ Married

Last name : _____ First Name: _____ Middle Initial: _____

Address:_____

City/State/Zip: _____

Patient's Date of Birth:_____ Preferred name/nickname: _____

Driver's License Number or State ID/Issued by the State of : _____/_____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

**Please mark off authorizing consent to reach you (circle preferred method of contact) :*

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

Occupation: _____ Employer/School: _____

Emergency Contact: Name :_____ Relationship:_____

Telephone number (s): _____

Referred by: _____

Who is Legally Responsible For Payment On This Account:

___ Self ___ Spouse ___ Parents ____ Mother ____Father ___Other

Please Print Name of Responsible Party:_____

Best Contact Phone Number: _____

Address *(if different from the patient)*:

_____

Email: _____

Relationship to patient:_____

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For patients under 18, or if under guardianship:

Please name the legal guardians(s)_____

Minor lives with primarily with :

____ Both parents ___Mother ___Father ___Other (specify)_____

First Parent's Name:_____ Date of birth:_____

Driver's License: _____

Address (if different) : _____

Occupation: _____ Employer: _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

Please mark off authorizing consent to reach you:

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

Second Parent's Name:_____ Date of birth:_____

Driver's License: _____

Address (if different) : _____

Occupation: _____ Employer: _____

Mobile Phone:_____ Home phone: _____

Work Phone: _____ Email: _____

Please mark off authorizing consent to reach you:

___ *Mobile calls/voicemail/text* ____ *Home phone* ____ *Work Phone* ____ *Email*

****

Payment in full is due at the time of service. As a courtesy this office will submit a claim on your behalf to the primary insurance you place on file. These benefits will process toward any available out-of-network benefit. If there are benefits payable, the insurance company will send reimbursement directly to the policyholder.

Primary Insurance Coverage

Name of Policyholder : _____

Policyholder Date of Birth: _____

Primary Insurance Company: _____

Contract/Policy Number :_____

Contract/Policy Group Number:_____

Contract effective date: _____

Relationship to Policyholder:_____

PLEASE SIGN BELOW :

My signature on this form serves as consent to submit an insurance claim to the insurance company I have placed on file. I acknowledge this claim will be sent electronically. If I seek care outside of the contract. I am aware that it is my responsibility to obtain prior authorization for services if required by my insurance plan. I am aware that I am responsible for all the charges that are incurred. I understand that I am responsible for all co-payments, amounts applied to deductibles, and other payments that may be deemed my responsibility by the payment sources and required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. If per the insurance company mandates in accordance to my plan.

Print name of Person responsible for payments: _____

Signature: _____Date:_____

WRCMW Credit Card and HSA/FSA Authorization Form

We require all patients to keep a valid and current form of payment on file due to our high volume of telemedicine services. Please complete all fields. You may cancel this authorization at any time by contacting us at (216) 230-8100 or billing@wrcmw.com. This authorization will remain in effect until canceled.

Credit Card Information ¡ÒÅÑÕÉÒÅÄ¢
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ /_____ Security Code (CVC2/CVV2/CID): _____
Cardholder ZIP Code (from credit card billing address): _____

(3 ! T&3 ! Card Information ¡ÏÐÔÉÏ ÎÁÌ¢
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ /_____ Security Code (CVC2/CVV2/CID): _____
Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize Western Reserve Center For Mental Wellness LLC (WRCMW) to charge my credit card above for agreed upon charges. I understand that my information will be saved to file for future transactions on my account.

I understand that if I provide my HSA/FSA card information, this card will be used first for payments. If my HSA/FSA card does not have sufficient funds, WRCMW will next use my credit card on file to complete payment of my remaining balance.

_____ _____

Patient / Payor Signature Date

WRCMW Practice Policies and Treatment Consent

Western Reserve Center For Mental Wellness

29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122

(216) 230-8100. - (216) 230-8215 fax

appointments@wrcmw.com

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PRACTICE POLICIES (revised 1/1/2021)

Thank you for the opportunity to work with you. Please review these practice policies and become familiar with them. Please ask any questions that you may have.

APPOINTMENTS AND CANCELLATIONS

Please remember to call or email the office to cancel or reschedule your appointment at least 24 hours in advance. You will be responsible for the entire appointment fee if cancellation is less than 24 hours. Please give us as much notice as possible when you realize you need to cancel or reschedule an appointment.

The standard meeting time for a follow up visit is 25 minutes. It is up to you, however, to determine the length of time of your appointments. Requests to change a 25 minute appointment to a 50 minute appointment need to be discussed with the health care provider in order for adequate time to be scheduled in advance.

Appointment/Service Fee Schedule (updated 1/1/2021):

- Comprehensive initial evaluation (90 minutes): $400
- Standard medication management with psychotherapy (25 minutes): $200
- Complex medication management with psychotherapy (50 minutes): $300
- Medication management appointments longer than 50 minutes will be charged an additional prorated fee of $300/hr for the additional time ($25 per 5 min).
- Telemedicine and phone appointments are charged at the same rate as in-office appointments.
- Phone calls or emails/texts to your health care provider lasting longer than 5 minutes will be charged a prorated fee of $300/hr ($25 per 5 min). If brief phone calls or emails/texts are frequent, they will be added together and charged at the prorated rate.
- Phone calls or emails/texts to the office nurse lasting longer than 5 minutes will be charged a prorated fee of $120/hr ($10 per 5 min).

- There is no charge for phone calls or emails/texts to the office staff for scheduling/canceling appointments, asking billing questions, or arranging payments.
- Call-in of prescriptions to your pharmacy when your provider is out of the office (holidays/weekends/evenings): $25 per call
- Call-in of prescriptions to your pharmacy because you failed to schedule a follow-up appointment at the interval requested by your provider, or because you missed/canceled/rescheduled your follow-up appointment: $25 per call
- Other services performed by your health care provider lasting more than 5 minutes will be charged a prorated fee of $300/hr ($25 per 5 min). These include but are not limited to: report or letter writing, attendance at meetings with other professionals, family conferences, and prior authorization requests/appeals.
- Appointments scheduled outside of regular office weekday hours or on weekends will be charged the standard appointment fee plus an additional $100/hr ($50 per 30 min).
- Preparation of documents or reports to be submitted to a lawyer or the court for any legal/court proceedings will be charged a prorated fee of $400/hr (minimum 15 minute charge).
- Should you or your lawyer request your provider's attendance at legal/court proceedings, you will be responsible for costs incurred at a rate of $500/hr (minimum 2 hour charge) for preparation, travel, and attendance.
- A $50 service charge will be charged for any checks returned for any reason.

Any of the above fees may be adjusted annually in January as deemed necessary.

*****Cancellations and re-scheduled appointments will be subject to a full charge if NOT RECEIVED AT LEAST 24 HOURS IN ADVANCE. This is necessary because a time commitment is made to you and is held exclusively for you. If you are late for an appointment, you may lose some of that appointment time. If your health care provider is late for an appointment, you will receive all of your allotted appointment time.*****

TELEPHONE/EMAIL ACCESSIBILITY

If you need to contact your provider between appointments, please leave a message on your provider's office voicemail or email. Your provider is often in appointments with other patients and not immediately available; however, they will attempt to return your message as soon as they can, within 48 hours. Sometimes they may be able to return your message after regular business hours, but there is no guarantee they can always do so. If a true emergency situation arises, please call 911 or go to your closest emergency room.

TEXT MESSAGES

Your provider or the office staff may text you for urgent appointment/scheduling communications, but due to health information privacy regulations, email or phone calls are preferred for all other communication.

SOCIAL MEDIA AND TELECOMMUNICATION

Due to the importance of your confidentiality and the importance of minimizing dual relationships, we do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc). We believe that adding clients as friends or contacts on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. If you have questions about this, please bring them up when we meet and we can talk more about it.

MINORS

If you are a minor, your parents may be legally entitled to some information about your treatment. Your provider will discuss with you and your parents what information is appropriate for them to receive and which issues are more appropriately kept confidential.

INSURANCE AND MANAGED CARE

This psychiatry practice does not participate in insurance panels (Dr. Miller is not "in-network" at this practice location). As a courtesy, our office will file the required appointment claim paperwork on your behalf to your insurance carrier. Your carrier may cover a portion of your visit, usually after a deductible is first met. Any reimbursement from your insurance company will be sent directly to the policyholder. Your insurance program is a contract between you and your insurance company, and this practice is not a party to that contract; all charges are your responsibility. If you are covered with Medicaid or a Medicaid-linked insurance, all services provided are excluded from coverage and no claims will be filed.

FINANCIAL RESPONSIBILITY FOR FEES AND PAYMENTS

All appointment/service fees (including fees for missed appointments) are due at the time of the service. We require that you place a credit card on file with our office for automatic payment processing following your appointment. By providing your credit card information during the registration process, you are authorizing this office to keep your credit card information on file. Credit card charges will be processed through either Stripe or Square merchant payment services. Charges will appear on your statement as either "WRCMW - Dr Noah Miller" or "SQ*Western Reserve Ctr."

If you prefer to use an FSA/HSA card, we require that you provide a backup credit card for payment of any charges in excess of your FSA/HSA card balance. If you prefer to pay by check or cash, or if you desire to use a different credit card than the one on file, please inform our billing specialist by phone or email (billing@wrcmw.com) prior to your appointment. A check returned for insufficient funds will incur a $50 fee.

If someone else is responsible for or has agreed to pay for your your health care, they will need to acknowledge this by consenting to pay for your charges during the online intake process. Our billing staff may reach out to them separately to verify their consent and document their contact information.

We do not offer payment plans and all fees are non-refundable. Unpaid balances beyond 60 days may lead to termination of your treatment with a referral to another psychiatrist. If you have any questions about billing, please call the office and choose the option for the billing specialist.

TERMINATION

Ending relationships can be difficult. Therefore, it is important to have a termination process in order to achieve some closure. The appropriate length of the termination depends on the length and intensity of the treatment. Your health care provider may terminate treatment after appropriate discussion with you and a termination process if it is determined that your treatment is not being effectively used or if you are in default on payment. Your provider will not terminate the therapeutic relationship without first discussing and exploring the reasons and purpose of terminating. If treatment is terminated for any reason or you request another provider, we will provide you with a list of qualified psychiatrists to treat you. You may also choose someone on your own or from another referral source. Should you fail to schedule an appointment for six or more months, unless other arrangements have been made in advance, for legal and ethical reasons, we must consider your psychiatric treatment here to be discontinued.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. ☐

BY CLICKING ON THE CHECKBOX BELOW I AM ALSO GIVING MY CONSENT TO PROVIDE PSYCHIATRIC TREATMENT FROM THE HEALTH CARE PROVIDERS AT WESTERN RESERVE CENTER FOR MENTAL WELLNESS LLC. ☐

_____ _____

Patient / Guardian Signature **Date**

WRCMW Cancellation Policy and Fee Acknowledgement

Western Reserve Center For Mental Wellness

29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122

(216) 230-8100. - (216) 230-8215 fax

appointments@wrcmw.com

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APPOINTMENT CANCELLATIONS AND NO-SHOWS

You will be charged the entire appointment fee if you miss your appointment.

Please remember to call or email the office to cancel or reschedule your appointment at least 24 hours in advance. You will be responsible for the entire appointment fee if you cancel or reschedule less than 24 hours notice before your appointment.

COMMUNICATION WITH YOUR PROVIDER IN BETWEEN APPOINTMENTS

Phone calls or emails/texts to your health care provider lasting longer than 5 minutes will be charged a prorated fee of $300/hr ($25 per 5 min). If brief phone calls or emails/texts are frequent, they will be added together and charged the prorated fee.

Instead of contacting your health care provider, please consider contacting the practice's nurse for medication questions or concerns that cannot wait until your next scheduled appointment. The fee for communication with the nurse is $120/hr ($10 per 5 min).

There is no charge for phone calls or emails/texts to the office staff for scheduling/canceling appointments, asking billing questions, or arranging payments.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. ☐

_____ _____

Patient / Guardian Signature **Date**

WRCMW Informed Consent for Psychotherapy

Western Reserve Center For Mental Wellness

29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122

(216) 230-8100. - (216) 230-8215 fax

appointments@wrcmw.com

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Informed Consent for Psychotherapy

General Information

The therapeutic relationship is unique in that it is a highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship will work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with me. Please read and indicate that you have reviewed this information and agree to it by filling in the checkbox at the end of this document.

The Therapeutic Process

You have taken a very positive step by deciding to seek psychiatric treatment, which may include elements of psychotherapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, result in considerable discomfort. Remembering unpleasant events and becoming aware of feelings attached to those events can bring on strong feelings of anger, depression, anxiety, etc. There are no miracle cures. I cannot promise that your behavior or circumstance will change. I can promise to support you and do my very best to understand you and repeating patterns, as well as to help you clarify what it is that you want for yourself.

Confidentiality

The appointment content and all relevant materials to the patient’s treatment will be held confidential unless the patient requests in writing to have all or portions of such content released to a specifically named person/persons. Specific consent to release psychotherapy notes is required in addition to the consent that is given to share medical and psychiatric information from a patient’s record. Limitations of such patient held privilege of confidentiality exist and are itemized below:

1. If a patient threatens or attempts to commit suicide or otherwise conducts him/her self in a manner in which there is a substantial risk of incurring serious bodily harm.
2. If a patient threatens grave bodily harm or death to another person.
3. If the psychiatrist has a reasonable suspicion that a patient or other named victim is the perpetrator, observer of, or actual victim of physical, emotional or sexual abuse of children under the age of 18 years.

4. Suspicions as stated above in the case of an elderly person who may be subjected to these abuses.
5. Suspected neglect of the parties named in items #3 and # 4.
6. If a court of law issues a legitimate subpoena for information stated on the subpoena.
7. If a patient is in psychiatric treatment or is being treated by order of a court of law, or if information is obtained for the purpose of rendering an expert's report to an attorney.

Occasionally I may need to consult with other professionals in their areas of expertise in order to provide the best treatment for you. Information about you may be shared in this context without using your name.

If we see each other accidentally outside of the psychiatry office, I will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to me, and I do not wish to jeopardize your privacy. However, if you acknowledge me first, I will be more than happy to speak with you to the extent that you feel comfortable engaging in any discussions in public or outside of the psychiatry office.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. ☐

_____ _____

Patient / Guardian Signature **Date**

WRCMW Consent for Telemedicine Consultation

Western Reserve Center For Mental Wellness

29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122

(216) 230-8100. - (216) 230-8215 fax

appointments@wrcmw.com

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CONSENT FOR TELEMEDICINE CONSULTATION

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telemedicine consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

CONSENT TO USE THE DOXY.ME SERVICE

Doxy.me is the technology service we will use to conduct telemedicine videoconferencing appointments. It is simple to use and there are no passwords required to log in. By signing this document, I acknowledge:

1. Doxy.me is NOT an Emergency Service and in the event of an emergency, I will use a phone to call 911.
2. Though my provider and I may be in direct, virtual contact through Doxy.me, neither SimplePractice nor Doxy.me provides any medical or healthcare services or advice including, but not limited to, emergency or urgent medical services.
3. Doxy.me facilitates videoconferencing and is not responsible for the delivery of any healthcare, medical advice or care.

4. To maintain confidentiality, I will not share my telemedicine appointment link with anyone unauthorized to attend the appointment.

5. In the event that Doxy.me is unavailable or not performing well enough to allow for adequate communication, my provider may choose to move my telemedicine appointment to another videoconferencing platform (such as Zoom or Psychology Today's Sessions service). If unforeseen technical difficulties do not allow for adequate telemedicine communication on any platform, my provider will instead call my primary phone number to complete the appointment as an audio phone call.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

BY CLICKING ON THE CHECKBOX BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT. ☐

_____ _____

Patient / Guardian Signature **Date**

4. The Right to See and Get Copies of Your PHI. Other than "session notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.

5. The Right to Get a List of the Disclosures I Have Made.You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.

6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.

7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 1/1/2021.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. ***By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.*** ☐

_____ _____

Patient / Guardian Signature **Date**

WRCMW Notice of Privacy Practices

Western Reserve Center For Mental Wellness

29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122

(216) 230-8100 - (216) 230-8215 fax

appointments@wrcmw.com

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. MY PLEDGE REGARDING HEALTH INFORMATION:

I understand that health information about you and your health care is personal. I am committed to protecting health information about you. I create a record of the care and services you receive from me. I need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this practice. This notice will tell you about the ways in which I may use and disclose health information about you. I also describe your rights to the health information I keep about you, and describe certain obligations I have regarding the use and disclosure of your health information. I am required by law to:

- Make sure that protected health information (“PHI”) that identifies you is kept private.
- Give you this notice of my legal duties and privacy practices with respect to health information.
- Follow the terms of the notice that is currently in effect.
- I can change the terms of this Notice, and such changes will apply to all information I have about you. The new Notice will be available upon request, in my office, and on my website.

II. HOW I MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

The following categories describe different ways that I use and disclose health information. For each category of uses or disclosures I will explain what I mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

For Treatment Payment, or Health Care Operations: Federal privacy rules (regulations) allow health care providers who have direct treatment relationship with the patient/client to use or disclose the patient/client’s personal health information without the patient’s written authorization, to carry out the health care provider’s own treatment, payment or health care operations.

I may also disclose your protected health information for the treatment activities of any health care provider. This too can be done without your written authorization. For example, if a health care provider were to consult with another licensed health care provider about your condition, we would be permitted to use and disclose your personal health information, which is otherwise confidential, in order to assist the health care provider in diagnosis and treatment of your condition.

Disclosures for treatment purposes are not limited to the minimum necessary standard. Because other health care providers need access to the full record and/or full and complete information in order to provide quality care. The word "treatment" includes, among other things, the coordination and management of health care providers with a third party, consultations between health care providers and referrals of a patient for health care from one health care provider to another.

Health Information Exchanges: We participate in one or more Health Information Exchanges. We, and other healthcare providers, may allow access to your health information through Health Information Exchange electronic networks to securely provide access to your health records for treatment, payment or other healthcare operations. This is a voluntary agreement. You may opt-out of a Health Information Exchange at any time by notifying our office medical records administrator at billing@wrcmw.com.

Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court or administrative order. I may also disclose health information about your child in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

III. CERTAIN USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION:

1. Therapy Notes: I do keep "therapy notes" and any use or disclosure of such notes requires your Authorization unless the use or disclosure is:

   a. For my use in treating you.

   b. For my use in training or supervising associates to help them improve their clinical skills.

   c. For my use in defending myself in legal proceedings instituted by you.

   d. For use by the Secretary of Health and Human Services to investigate my compliance with HIPAA.

   e. Required by law and the use or disclosure is limited to the requirements of such law.

   f. Required by law for certain health oversight activities pertaining to the originator of the session notes.

   g. Required by a coroner who is performing duties authorized by law.

   h. Required to help avert a serious threat to the health and safety of others.

2. Marketing Purposes. As a health care provider, I will not use or disclose your PHI for marketing purposes.

3. Sale of PHI. As a health care provider, I will not sell your PHI in the regular course of my business.

IV. CERTAIN USES AND DISCLOSURES DO NOT REQUIRE YOUR AUTHORIZATION.

Subject to certain limitations in the law, I can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the patients who received one form of care versus those who received another form of care for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counterintelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, I may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. I may use and disclose your PHI to contact you to remind you that you have an appointment with me. I may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that I offer.

V. CERTAIN USES AND DISCLOSURES REQUIRE YOU TO HAVE THE OPPORTUNITY TO OBJECT.

1. Disclosures to family, friends, or others. I may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

VI. YOU HAVE THE FOLLOWING RIGHTS WITH RESPECT TO YOUR PHI:

1. The Right to Request Limits on Uses and Disclosures of Your PHI. You have the right to ask me not to use or disclose certain PHI for treatment, payment, or health care operations purposes. I am not required to agree to your request, and I may say "no" if I believe it would affect your health care.

2. The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full. You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. The Right to Choose How I Send PHI to You. You have the right to ask me to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and I will agree to all reasonable requests.
4. The Right to See and Get Copies of Your PHI. Other than "therapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. I will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and I may charge a reasonable, cost based fee for doing so.
5. The Right to Get a List of the Disclosures I Have Made. You have the right to request a list of instances in which I have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. I will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list I will give you will include disclosures made in the last six years unless you request a shorter time. I will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost based fee for each additional request.
6. The Right to Correct or Update Your PHI. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that I correct the existing information or add the missing information. I may say "no" to your request, but I will tell you why in writing within 60 days of receiving your request.
7. The Right to Get a Paper or Electronic Copy of this Notice. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.
8. The Right to Opt-out of Health Information Exchanges: You may request that we not share your health records via Health Information Exchanges at any time by notifying me or my office medical records administrator.

EFFECTIVE DATE OF THIS NOTICE

This notice went into effect on 1/1/2021.

Acknowledgement of Receipt of Privacy Notice

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), you have certain rights regarding the use and disclosure of your protected health information. ***By checking the box below, you are acknowledging that you have received a copy of HIPAA Notice of Privacy Practices.***

_____ _____

Patient / Guardian Signature **Date**

WRCMW Release of Information Consent

Western Reserve Center For Mental Wellness
29525 Chagrin Blvd. Suite 301, Pepper Pike, OH 44122
(216) 230-8100 (216) 230-8215 fax
hello@wrcmw.com

** indicates a required field*

Patient information:

Patient name:

Patient date of birth

Patient address:

Patient (or parent/guardian) phone number:

Patient (or parent/guardian) email:

* I authorize Noah Miller MD and Western Reserve Center For Mental Wellness LLC to:

- [ ] Send
- [ ] Receive

* The following information:

- [ ] Medical history and evaluation(s)
- [ ] Mental health history and evaluation(s)
- [ ] Developmental and/or social history
- [ ] Educational records
- [ ] Progress notes, and treatment or closing summary
- [ ] *Alcohol/drug dependence/abuse history
- [ ] *Therapy notes
- [ ] Entire record (excluding * items)
- [ ] Other

To / From:

Name:

Address:

Phone:

Fax:

Email:

* Your relationship to client:

- ○ Self
- ○ Parent/legal guardian
- ○ Legal representative
- ○ Other

* The above information will be used for the following purposes:

- ☐ Planning appropriate treatment or programming
- ☐ Continuing appropriate treatment and coordination of care
- ☐ Determining eligibility for benefits or program
- ☐ Updating files
- ☐ Scheduling and confirming appointments
- ☐ Paying for services and account inquiries
- ☐ Other
- ☐ This disclosure is at the patient's (or parent's/guardian's) request

I, the undersigned, authorize Noah Miller MD and Western Reserve Center For Mental Wellness LLC to release/receive information to/from my medical records as described above. I understand and acknowledge that the medical record may contain

information regarding psychiatric disorders, alcohol and/or drug dependence/abuse, HIV test results, and/or AIDS-related conditions.

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that information used or disclosed according to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization.

I understand that I have a right to refuse to sign this authorization. I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my failure to sign this authorization.

I understand that there may be charges for the copying and release of this information and accept financial responsibility.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

* **Signature:** _____

I consent to sharing information provided here.

*** Date:**

Witness signature (if client is unable to sign):

Witness Date:

WRCMW Intake Questionnaire

If you are the patient's parent/guardian, please answer the following questions from your child's perspective. If you are not certain of your child's perspective, please answer to the best of your ability based on your knowledge of your child and the current situation. It is OK to skip questions that you feel do not pertain to your child.

What brings you to see me at this time? Is there something specific, such as a particular event or symptom(s)? Be as detailed as you can:

What are your goals for treatment?

Have you seen a mental health professional before?

- ○ Yes
- ○ No

Specify all medications and supplements you are presently taking and for what reason. (This includes medical marijuana if recommended/authorized by a certified physician):

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Do you have any medication allergies that you know of?

- Yes
- No

Who is your primary care physician? Please include type of MD, name and phone number.

Do you have any medical (non-psychiatric) conditions?

- Yes
- No

Please check if you have recently experienced any of the following symptoms:

- [ ] Headache
- [ ] High blood pressure
- [ ] Gastritis or esophagitis
- [ ] Hormone-related problems
- [ ] Head injury
- [ ] Angina or chest pain
- [ ] Irritable bowel
- [ ] Chronic pain
- [ ] Loss of consciousness
- [ ] Heart attack
- [ ] Bone or joint problems
- [ ] Seizures
- [ ] Kidney-related issues
- [ ] Chronic fatigue
- [ ] Dizziness
- [ ] Faintness
- [ ] Heart valve problems
- [ ] Urinary tract problems
- [ ] Fibromyalgia
- [ ] Numbness & tingling
- [ ] Shortness of breath
- [ ] Diabetes
- [ ] Hepatitis
- [ ] Asthma
- [ ] Arthritis
- [ ] Thyroid issues
- [ ] HIV/AIDS
- [ ] Cancer
- [ ] Other

Do you drink alcohol?

- ○ Yes
- ○ No

Do you use recreational drugs?

- ○ Yes
- ○ No

Do you have suicidal thoughts?

- ○ Yes
- ○ No

Have you ever engaged in non-suicidal self-harming behaviors?

- ○ Yes
- ○ No

Have you ever attempted suicide?

- ○ Yes
- ○ No

Do you have thoughts or urges to harm others?

- ○ Yes
- ○ No

Have you ever been hospitalized for a psychiatric issue?

- ○ Yes
- ○ No

Is there a history of mental illness in your family?

- ○ Yes
- ○ No

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others. With family, etc...

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it? If still in school, please indicate "student."

What strengths/talents do you have?

What do you like to do for leisure?

Please check if you have experienced any of the following symptoms in the past six months:

- [ ] Increased appetite
- [ ] Decreased appetite
- [ ] Trouble concentrating
- [ ] Difficulty sleeping
- [ ] Excessive sleep
- [ ] Low motivation
- [ ] Isolation from others
- [ ] Fatigue/low energy
- [ ] Low self-esteem
- [ ] Depressed mood
- [ ] Tearful or crying spells
- [ ] Anxiety
- [ ] Fear
- [ ] Hopelessness
- [ ] Panic
- [ ] Other

What else would you like me to know?

Thank you for taking the time to complete this questionnaire. I look forward to meeting you soon!