Patient Demographic Information:

Full Birth Name:

Preferred Name

Preferred Pronouns

Date of Birth

Cell Phone

Email Address

Home Address

Are you paying out of pocket?

If you are paying out of pocket please type n/a in the boxes below

Insurance Company

Member ID

Group Number

Date plan took effect

If you are not the primary insurance holder please provide the following (Type in n/a if inapplicable)

Primary Insurance Holder's Full Name

Date of Birth

Address

Do you have a deductible?

If you have a deductible, has it been met?

Do you receive state managed Medicare or Medicaid benefits directly/indirectly, as primary or secondary insurance?

****WE CANNOT TREAT STATE MANAGED MEDICARE/MEDICAID BENEFICIARIES****

Larson Mental Health will bill your eligible insurance but please recognize it is your responsibility to understand the following information as applicable:

- Deductible amount
- Deductible met
- Co-Insurance amount if applicable
- Co-Pay amount
- Your financial responsibility for your appointments

What is your preferred pharmacy name, address (including zip code), phone number?

Emergency Contact Information/Next of Kin:

Name

Relationship

Phone Number #

Address

JS (initials) I certify that the above demographic information is true and accurate to the best of my knowledge.

JS Initials of Parent or Guardian, if Patient is under the age of 15

Policy and Information About Controlled Substances

It is Larson Mental Health's policy to limit quantity and duration of most controlled substance prescriptions, as well as clarify the expectations inherent in the use of controlled substances.

Controlled substances include (but are not limited to) the following:

Stimulants ADD/ADHD/Narcolepsy	Benzodiazepines Anxiety/Panic	Sleep Aids
Ritalin / Concerta	Xanax	Ambien
methylphenidate	*alprazolam*	*zolpidem*
Vyvanse	Ativan	Lunesta
lisdexamfetamine	*lorazepam*	*eszopiclone*
Adderall	Klonopin	Belsomra
amphetamine	*clonazepam*	*suvorexant*
Focalin	Valium	Sonata
dexmethylphenidate	*diazepam*	*zaleplon*
Others	Restoril	Others
	temazepam	
	Others	

PLEASE NOTE: Pain medications can have serious interactions with many medications (INCLUDING DEATH). Please list any pain medications you are taking where indicated. Pain medications are not prescribed at Larson Mental Health.

Understand the Laws and Risks of Controlled Substance Medications

All controlled substances are strictly regulated and monitored by the Drug Enforcement Agency (DEA).

These medications carry the risk of dependence or addiction and, in some cases, death. Benzodiazepines and controlled sleep aids significantly increase the risk of falls, overdose, depression, cognitive impairment, and, with continued use, are likely to cause early dementia. There are many safer medication choices that in combination with therapies and lifestyle/habit modifications, can be more effective and longer lasting in reducing symptoms and insomnia.

Benzodiazepines cause more harm than good in PTSD as they prevent the mind/body's ability to work through (or process) trauma. As a result, these unprocessed traumas can cause unpredictable worsening of symptoms and tragic outcomes.

Patients who are taking prescribed narcotic/opioid pain medications, are unable to stop alcohol consumption, or use illegal drugs will not be prescribed benzodiazepines or controlled sleep aids. This is not just a standard policy; it is for your safety as these combinations can be deadly. Similarly, stimulant medications will not be prescribed to those who use illegal drugs.

Controlled Substance Policy Cont

In order to provide you with safe, appropriate, and effective treatment, and to adhere with DEA regulation, it is our policy to:

- Minimize controlled substance prescriptions.
- Most controlled substance prescriptions will be prescribed in 30-day quantities and may not exceed 90-day quantities.
- Stimulants will not be filled early.
- Benzodiazepines will not be filled early except in the very rare case your provider deems it necessary to fill. *Please note, if your medication is stolen or lost, you will be required to provide a signed police report. If you have used your medication at a higher dose than was prescribed, it will not be refilled. If this occurs, you may need to seek treatment at an emergency department to avoid potentially dangerous withdrawal symptoms.
- New patients who are already taking benzodiazepines on a daily basis will be provided a schedule to safely taper (gradually reduce and discontinue or, at a minimum, reduce to less than daily use). Your prescription will not be “cut off” or abruptly stopped. A contract will be required, however, if you do not wish to make changes to your prescription you will need to find a new practice for benzodiazepine prescriptions.
- Benzodiazepines are not prescribed for PTSD.
- Controlled sleep-aids other than benzodiazepines will also be tapered over a 6-month period, to a maximum monthly use of 10 nights.
- See patients, at a minimum, within 90 days of last visit.
- If patients are not seen within the 90-day window, we are unable to refill controlled substance prescriptions *
  *(In rare cases, a small quantity bridge will be prescribed up to the next scheduled appointment if deemed necessary by your provider)

Please understand that this policy is not meant to be judgmental, nor is it intended to accuse you of anything illegal, immoral, or of abusing medication. People can and often will become dependent on their medications (particularly benzodiazepines), despite the fact that they have been taking them as prescribed. If you are unwilling or feel that you are unable to conform to the policy outlined above, you may wish to consider looking for a new provider for those medications that are covered by the policy.

(initials) I have read and acknowledge and agree to the Larson Mental Health policy on controlled substance prescriptions and I have informed Larson Mental Health of any considerations or contraindications that may apply to me. I am aware that the prescribing of controlled substances is not an exact science and I acknowledge that no guarantees have been made or implied to me as to the results of the use of controlled substances or my satisfaction with the results, nor are there any guarantees against unforeseeable or unexpected results. The use of controlled substances have been thoroughly explained to me and I fully understand the benefits and risks of utilizing them, including the possibility of complications.

(initials) I give my consent to LMH to check my medication history via Surescripts.

Initials of Parent or Guardian, if Patient is under the age of 15

Appointment No-Shows and Late Cancellation Policy

In the case of appointment no-shows or late cancellations (generally considered less than 24 hours before the appointment time), fees will be charged based on the self-pay rate of the practice. Showing up 10 minutes late for a 30 minute Follow Up constitutes a No Show; Showing up 15 minutes late to a 50 minute Follow Up; and showing up 20 minutes late for a 90 minute New Patient Evaluation constitutes a No Show. The fees are as follows:

- 90-minute initial patient evaluation - $325.00
- 50-minute follow up appointment - $230.00
- 30-minute follow up appointment - $160.00
- 60-minute therapy appointment - $130

Additionally, multiple appointment no-shows or late cancellations may result in discharge from the practice, particularly if they occur consecutively. Regular follow-up is necessary to ensure safe and appropriate treatment. If you are unable or unwilling to attend those appointments, it may be necessary for you to find a new provider, as prescriptions will not be continued without proper follow- up.

Rarely, exceptions to this policy may be made based on specific circumstances or hardship, in compliance with applicable laws.

Everyone's time is valuable, and when appointment times go unfilled due to a no-show or a late cancellation, it is not fair to other clients who would have liked to have taken that appointment and would have arrived on time.

We also recognize that your time is valuable, and we do our best to stay on schedule, however, there are times when patients may require an extended appointment. We kindly ask for your understanding in the rare case of a patient needing extra time, in that, we would extend the same courtesy to you.

You hereby agree that the practice and its providers will not be liable for any failure to provide, or delay in providing, services to you in the event that the practice and its providers are assisting another patient(s).

(initials) I have read and acknowledge and agree to the Larson Mental Health policy on appointment no-shows.

(initials) I acknowledge that failure to complete an appointment as scheduled will result in a no show fee charge.

JS Initials of Parent or Guardian, if Patient is under the age of 15

Telehealth Policy

Larson Mental Health providers are legally obligated to only provide treatment to patients that are in the state of Colorado at the time of the service. Further, some insurance plans do not have Telehealth as a covered service. It is the responsibility of the patient to verify that Telehealth is a covered service in their plan and all Telehealth appointments not covered by a patient's insurance will be billed to the patient as the self pay rate.

Should you engage in a telemedicine visit with Larson Mental Health and/or any other of the practice's providers (each, a "Provider"), you further agree to the following:

1. My Provider has explained to me that the telemedicine visit will not be the same as a direct Patient/Provider visit due to the fact that I will not be in the same room as my Provider.
2. I understand that my participation in the telemedicine visit is entirely voluntary. I also understand that either I or my Provider can discontinue the telemedicine visit at any time for any reason.
3. I understand that although reasonable steps are taken to secure the telemedicine communications between me and my Provider, there is no guarantee of security and there are potential risks involved in using this technology including, without limitation, interruptions, disconnections, unauthorized access, and technical difficulties.
4. My Provider has discussed the risks, benefits and alternatives to a telemedicine visit with me in a manner that I understand.
5. I have had the opportunity to ask questions regarding the use of the practice's telemedicine services for my telemedicine visit, and my questions have been answered to my satisfaction.
6. I agree to do my best to ensure that my internet connection is reliable, including but not limited to, not holding the session in a moving car.

My signature/initials below evidences my voluntary agreement to, and understanding of, all of the terms set forth in in this Telehealth Policy, that I have the legal power and authority to sign this policy, and that this policy constitutes a valid, legal document that is binding and of full force and effect. I understand and agree that this policy is effective on the date signed below until it is revoked by me in writing, which revocation shall be prospectively effective.

JS (initials) I have read and acknowledge and agree to the Larson Mental Health policy on Telehealth appointments and I attest that should I

schedule and receive a Telehealth appointment from a Larson Mental Health provider, I will do so ONLY from within the state of Colorado.

JS Initials of Parent or Guardian, if Patient is under the age of 15

Credit Card and Payment Policy

In order to help ensure prompt payment for services rendered, it is the policy of Larson Mental Health to keep an active credit card on file for each client.

Payment is required at time of service, and may include (but is not limited to) the following:

- full cost of appointment if paying out of pocket
- insurance co-payment if required
- insurance deductible
- no-show or late cancellation (this is not covered by insurance and does not apply to your deductible)
- additional services not covered by insurance, some examples may include (but are not limited to) letters to employers or disability claim forms; letters to professors/teachers or employers justifying absences or requesting accommodations; service animal letters for landlords. These fee's will be discussed with you prior to providing these services.

In the event that there is an outstanding balance due for services rendered to you by the practice, payment is due upon the earlier of: (1) prior to your next appointment, or (2) within 30 days of the date provided in the practice's initial invoice or statement, whichever is sooner. Payments not received by the practice after 30 days of an initial statement date will be assessed a late fee of $25 and that this fee will accrue at a rate of $25 per 30 days late. Accounts in arrears more than 90 days will be sent to collections. The practice has the right to adjust its payment policies and procedures in order to comply with applicable laws and third-party payer rules.

You must provide updated insurance information to the practice in a timely manner should your insurance, or conditions of your insurance, change at any point. It is your responsibility to understand your insurance benefits including, without limitation, your copays, coverage and deductibles, and any required referrals.

By initialing below, you authorize the practice to bill your insurance company for services rendered and that payment be made by the insurance company directly to the practice. You understand that there is no obligation for the practice to collect money on your behalf. Any deductibles or copays owed to the practice pursuant to your insurance policy will not be waived. Unpaid copays and amounts subject to your deductible, if any, may be reported to your insurance carrier since it is a requirement of your insurance plan and may affect my insurance coverage.

Further, the practice may have to contact your insurance company for an explanation of benefits. If you or your insurance company have given the practice incorrect information, then you agree to accept responsibility for payment of any amount not paid by your insurance company. By initialing below, you authorize the practice to release to your insurance company and its designated managed care company (if applicable) all information necessary to determine the benefits for services.

I acknowledge that I am not or have not in the past received Medicare/Medicaid benefits.

In the event that Larson Mental Health does not participate in my insurance network, I agree that I am financially responsible for and will pay the entirety of incurred charges for all services and products provided by the practice and its employees, contractors and providers. I understand that Larson Mental Health has the right to forward unpaid accounts to a collections agency and I agree to bear and reimburse the practice for all costs associated with its collection efforts on my account.

(initials) I understand and agree to the terms of the practice's Credit Card and Payment Policy that I will pay all charges incurred by the practice in accordance with the practice's then-current payment policies and procedures. I agree that I am financially responsible for and will pay all incurred charges for all services and products provided by the practice and its employees, contractors and providers. I agree that Larson Mental Health does not participate in every insurance network and does not participate in Medicare/Medicaid.

Initials of Parent or Guardian, if Patient is under the age of 15

Document Production and Phone Consultation Fee Schedule

**Because insurance companies do not cover your providers time for document production, the following fee schedule will apply for all document production requests. **

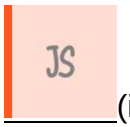
General accommodation letter - $30.00

Disability paperwork completed at insurance's request - $50.00 (fee may increase depending on complexity of request).

All patient phone conversations running more than 15 minutes - $145.00 (the price for a 30- minute follow-up appointment)

Difficult prescription prior authorizations (PA's taking more than 15 minutes) - $30.00

Please keep in mind that this list is not exhaustive. The cost of other documentation will be determined based on the specifics of the request.



(initials) I have read and acknowledge the Larson Mental Health policy regarding the collection and holding of credit card numbers, document production, and consultation fee schedule.


Initials of Parent or Guardian, if Patient is under the age of 15

Consent to Treatment

Persons over the age of 15 must give voluntary consent for mental health treatment. Your signature (or that of your guardian), will demonstrate consent for receiving mental health treatment from Larson Mental Health.

I voluntarily consent to mental health treatment as performed by Larson Mental Health and its employees. Treatment may include assessment, screening, psychotherapy, and psychiatric medication prescription and management. I understand that mental health treatment may involve certain risks and benefits and I understand these risks and benefits. I also understand the risks and benefits of declining treatment. I am also aware that I have the right to request information about alternative treatment options, should they exist.

- you may revoke this treatment consent at any time.
- your treatment will be individualized based on your particular needs, and may involve medication, psychotherapy, referral to outside treatment, or some combination thereof.
- you may involve family or loved ones in your care, if you choose.
- treatment is entirely confidential and none of the information that you share with your treatment provider will be shared with anyone outside of Larson Mental Health, without your permission, except as required by law.
- if medication is prescribed, potential risks and benefits of the prescribed medication will be explained to you.
- all treatment is entirely voluntary.

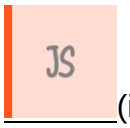
In the event of an emergency, or a situation in which you could reasonably expect an emergency to arise, you agree to call 911 or visit the nearest emergency room and follow the directions of emergency personnel.


(initials) My initials and signature on this form below evidences my agreement to all of the terms set forth in this Consent and that I am the patient or am authorized to act on behalf of the patient to sign this Consent. This Consent form has been explained to me and I've had an opportunity to ask questions and my questions have been satisfactorily answered concerning it. I have read the above and understand it. I accept the risks and complications of the services provided by Larson Mental Health. No guarantees about results have been made. I understand and accept the above and hereby authorize and give my informed consent for Larson Mental Health to provide me with mental health and related services. I understand that this Consent is effective on the date signed below and that I may revoke this Consent in writing. My revocation will not be effective for actions already taken by Larson Mental Health or that are in progress and will only be prospectively effective.


Initials of Parent or Guardian, if Patient is under the age of 15

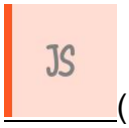
Confidentiality

Your records will be held in strict confidentiality, as required by state and federal law, including the health insurance and portability and accountability act (HIPAA). There are exceptions to the rules of confidentiality, and these include situations in which your treatment provider may reasonably believe that a threat of serious harm may exist. This may include, without limitation, threats of self-harm (suicide), harm to others (homicide, assault, etc.), suspected child abuse, elder abuse, or the abuse of at-risk adults. In these circumstances, your treatment provider is legally obligated to report these situations to the appropriate authorities.


(initials) I have read and acknowledge the Larson Mental Health policy regarding Confidentiality.


Initials of Parent or Guardian, if Patient is under the age of 15

Acknowledgement of Receipt of Notice of Privacy Practices


(initial) I acknowledge that I received a copy of the practice's Notice of Privacy Practices (NPP). I understand that the document is available to me and that to receive a copy of it, I need only request to receive a copy of it from my treatment provider.


Initials of Parent or Guardian, if Patient is under the age of 15

Additional Services Policy

Larson Mental Health may require QBtest services for the diagnosis and treatment of ADHD. The use of such services will be required in the event no prior ADHD diagnosis or treatment exists or in the case a prior ADHD diagnosis was made by a telehealth mental health practice. Larson Mental Health providers could, at their discretion, require QBtesting for diagnostic clarification or in other clinical applications. Larson Mental Health may also require testing to determine efficacy of existing prescriptions.

Billing Code	Description	Price
96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed	$130

In the event these additional services are not covered by your insurance carrier, you understand that:

- Payment for these services will be due at the time of service
- If Larson Mental Health is considered out of network for your insurance carrier, you will be responsible for the full amount.

I understand that my insurance carrier may not pay for the above services. I understand that by initialing, I will be fully responsible for the total charge(s) for any service denied as non-covered. I understand that should my insurance carrier not cover the services, I will pay the provider the amount due for the services rendered.

I acknowledge that if I do not have a prior ADHD treatment or diagnosis, I will be required to complete a QBtest, in addition to an evaluation and assessment appointment, in order to be prescribed ADHD medication.

Initials of Parent or Guardian, if Patient is under the age of 15

Patient Behavior and Termination Policy

Larson Mental Health is committed to treating each patient with dignity and respect. Similarly, it is the expectation that patients have the responsibility to treat everyone in the community, including staff and other patients with respect. Inappropriate behavior will not be tolerated and could result in discharge from the practice.

Examples of inappropriate behavior include but are not limited to:

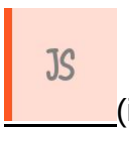
-Disrespectful, insulting or hurtful comments towards staff members or other patients
-Threatening or abusive language
-Profanity or other offensive language
-Threatening, intimidating or unwelcome physical behavior

Larson Mental Health also sets out all practice policies in a clear manner, both in these New Patient Documents, and also on its website. Being familiar with these policies and communicating in a respectful manner with practice staff will ensure that misunderstandings don't occur and that all expectations are reasonable.

From time to time, Larson Mental Health may determine that our practice cannot meet the treatment needs of the patient. This could be due to the high acuity of the patient (ie. the degree of care needed). This could be due to the frequency of the patient needing assistance and access to providers during off hours; patient's ability to successfully attend appointments, either in person or via the telehealth platform, and following the providers recommendations; or a termination could occur when a provider determines that the patient's needs would be better met by a provider outside of the Larson Mental Health.

Additionally, patient termination could occur due to lack of timely payment, multiple No Show or missed appointments, or if a provider discovers that a patient is either filling Larson Mental Health prescriptions at multiple pharmacies or being seen and prescribed medication by another provider. Termination could also occur if a patient refuses to comply with his/her/their provider's schedule for Follow Up appointments.

Should a violation of this Behavior and Termination policy occur, the patient will be notified by a Larson Mental Health staff member. Continued violation may result in discharge from the practice. In the event dismissal is determined, patients will be notified in writing and given a reasonable time to identify a new provider. During that transition period, medication refills and appointments will continue to be handled by your Larson Mental Health provider. Larson Mental Health complies with all state and practice regulations regarding patient abandonment.



(initials) I have read and acknowledge the Larson Mental Health policy

Patient Behavior and Termination.

JS

_____Initials of Parent or Guardian, if Patient is under the age of 15

Signature Page

Today's Date Full name

My signatures below indicate all the information I have provided is true to the best of my knowledge and I have read and agree to the policy's listed separately below.

Demographic and Insurance Information: Signature

Signature

Consent to Treatment: Signature

Signature

Controlled Substance Policy: Signature

Signature

Telehealth Policy: Signature

Signature

Credit Card and Payment Policy: Signature

Signature

Document Production & Consultation Fee Schedule: Signature

Signature

No-Show and Late Cancel Appointment Policy: Signature

Signature

Patient Behavior and Termination Policy: Signature

Signature

Acknowledgement of Receipt of NPP: Signature

Signature

Additional Services Policy: Signature

Signature

Attachment of both Front and Back of Patient Insurance Card

Image

Image