

Patient Name: _____

Behavioral Health History

Received help or treatment (psychiatric, psychological, counseling) before? Yes No Marital counseling
If so: When did you start? _____/_____/_____ When did you finish or stop? _____/_____/_____ (Current, see below)

Who was the therapist _____ Were you ever hospitalized? Yes No
and/or doctor? _____ Where and when? _____

Address _____ Phone _____

Past medications for problems (psychiatric, Yes *Current medications are*
psychological, emotional, behavioral) ? No *to be listed (below) in the*

The Psychiatrist: or Non-psychiatrist prescribing: _____ *Medical History section*

Name or type of psychiatric _____
medication in the past ? _____

Substance Use History

Have you ever abused drugs or alcohol? Yes No If yes, please describe: _____

Average amount of alcohol used: _____ Tobacco Use: _____

Medical History & Treatment	Illnesses, conditions, surgeries	_____ _____ _____ _____
	Current Prescription & Nonprescription Medications	_____ _____ _____
Medication allergies		
Regular M.D. (Primary Care Physician) or other: _____		Phone: _____
Last physical examination (approximate date): _____		

Family History: Are there any significant psychiatric conditions or addiction problems (alcohol, drugs) in your biologic* family? _____

_____ * Birth family (kin)

Patient Name _____

Consent for Treatment (Please read and sign all sections, For patients who are accompanied by another party who is responsible for payment, see the box at the bottom of this page)

I certify that I am the patient, or the patient's parent or guardian, and have read this form completely. I authorize the doctor/ therapist to evaluate and treat me the patient, psychologically, psychiatrically and or medically as appropriate. The purpose of the evaluation and treatment in progress will be explained during the course of the care. I also understand that while the course of psychological/ psychiatric counseling and other interventions is designed to be helpful, it may at times be difficult or uncomfortable.

_____ Date: _____
Patient's Signature or Signature of Responsible Party

I understand that even though I may have insurance coverage, I am ultimately responsible for payment, unless there is a contractual exclusion to this between Dr. Westerback and the health plan (such as USBHPC, Pacificare, or Blue Cross). I may not name any other party as the financially responsible party and I agree to the terms of this payment policy.

_____ Date: _____
Patient's Signature or Signature of Responsible Party

I authorize release of medical information necessary to process insurance claims, certify care as necessary, conduct case management and quality-of-care improvement programs, and other routine purposes related to my Health Plan.

_____ Date _____
Patient's Signature or Signature of Responsible Party

I give my consent to allow Dr. Westerback to communicate and share routine & basic information concerning my care (including medication), with:

- | | |
|--|--|
| <input type="checkbox"/> party who referred me (i.e., therapist, doctor, or other health professional) | <input type="checkbox"/> No - no consent given |
| <input type="checkbox"/> my Primary Care Physician listed on Page 2 of this form | <input type="checkbox"/> No - no consent given |
| <input type="checkbox"/> Other (counselor, other doctor) _____ | <input type="checkbox"/> Not applicable |

More detailed information will require a separate consent (verbal or written) from the patient allowing communication between Dr. Westerback and a specifically named party.

_____ Date _____
Signature of Patient or Responsible Party

Responsible Party when not the patient (Complete this section **only** if someone other than the patient (e.g. a parent or guardian) is responsible for payment. Please note if you signed the consent for treatment list (above) you may not list another party as the financially responsible party,

Last Name if Different Than the Patient's _____ First _____ MI _____ Home Phone # _____

Residence Address _____ City _____ Zip Code _____

Social Security Number _____ Date of Birth _____ Driver's License # _____

Employer _____ City _____ Occupation/Title _____ Phone Number # _____

Spouses Name (if Different From Above) _____ Employer / Occupation _____ Work Phone # _____

DARYL WESTERBACK, M.D.

PATIENT RIGHTS AND RESPONSIBILITIES

In accordance with federal, state, and other regulations, Dr. Westerback shall recognize and protect patient's rights and educate patients regarding their health care responsibilities.

A. Patient Rights

1. **Access to Care:** The patient has the right to impartial access to treatment or accommodations that are available or medically indicated, regardless of race, creed, sex, age, handicap, national origin, cultural, economic, educational, or religious background.
2. **Respect:** The patient has the right to considerate, respectful care at all times, and with recognition of his/her personal dignity. The care of the patient will include consideration of the psychosocial, spiritual, and cultural variables that influence the perceptions of illness.
3. **Research:** Participation by patients in the gathering of data for research purposes should be voluntary. The patient has a right to be advised as to the reason for the presence of any individual.
4. **Information:** The patient has the right to obtain, from the practitioner responsible for coordinating his/her care, complete and current information concerning his/her diagnosis (to the degree known), treatment, and any known prognosis.
5. **Consent:** The patient has the right to reasonable informed participation in decisions involving his/her health care. Where medically significant alternatives for care or treatment exist, the patient shall be so informed.
6. **Refusal of Treatment:** The patient may refuse treatment to the extent permitted by law, and the patient has a right to be informed of the medical consequences of such refusal. When refusal of treatment by the patient or his/her legal guardian prevents the provision of appropriate care in accordance with professional standards, the relationship with the patient may be terminated upon reasonable notice.
7. **Consultation:** The patient, at his/her own request and expense, has the right to consult with another physician for a second opinion.
8. **Confidentiality:** The patient has the right to have his/her personal health information accessed only by individuals directly involved in his/her treatment or in the monitoring of its quality. The patient has a right to expect all communications and other records pertaining to his/her care, including the sources of payment for treatment, to be treated as confidential.
9. **Note on Confidentiality:** All information between the doctor and the patient is held in strict confidence except: 1) when the patient or guardian authorizes the release of information; 2) when the patient is judged by the doctor to be immediately dangerous to him/her self or to others; or 3) when the doctor is required by law to follow an exclusion to confidentiality, as when the doctor suspects child or elder abuse and/or neglect. Dr. Westerback may provide copies of your medical records following your specific written consent to release information to a specific party. Fees for this service vary due to age and volume of records requested. This fee and responsibility of payment of this fee will be discussed with you prior to the release of these records.

B. Patient Responsibilities

1. **Provision of Information:** The patient has the responsibility to provide, to the best of his/her knowledge, accurate and complete information about present complaints, past illness, hospitalizations, medications, and other matters relating to his/her health. He/she has the responsibility to report unexpected changes in his/her condition to the responsible practitioner. A patient is responsible for reporting whether he/she clearly comprehends a contemplated course of action and what is expected of him/her. The patient is responsible for following the treatment plan recommended by the practitioner primarily responsible for his/her care.
2. **Refusal of Treatment:** The patient is responsible for his/her actions if he/she refuses treatment or does not follow the practitioner's instructions.
3. **Understanding:** The patient is expected to request an explanation if he/she does not understand the illness or treatment.
4. **Change:** The patient is responsible for notifying the medical staff of any changes in condition.
5. **Appointments:** The patient is responsible for keeping appointments.

6. **Cancellations and Missed Appointments:** Please contact our office as soon as you know you cannot keep your appointment. When you do not give 24 hours advance notice or when you fail to appear for a scheduled appointment, you will incur a charge of the full appointment rate (not your usual co-pay) These fees are due prior to or upon the next scheduled visit
7. **Financial Obligation:** The patient is responsible for his/her bill, until he/she is determined to be eligible for insurance or eligible for assistance from a specific government program. The patient is responsible to pay for amounts that may be applied to their annual deductible. The patient is responsible for charges arising out of appointments missed without 24 hour prior cancellation notification. Co-payments are due and payable at the time services are rendered.
8. **Prescription Medicines:** If medicine is prescribed, you should obtain needed refills at the time of your appointment. Dr. Westerback will provide a prescription or refills for more than sufficient medication to reach the next scheduled appointment. The follow-up appointment is set by Dr. Westerback solely on the basis of his assessment of your need for monitoring. The interval could be from days to months ahead, depending on his assessment of your individual need. All patients who receive ongoing medication prescriptions must schedule an appointment for at least every six months, so Dr. Westerback can assess your current medication and progress. This will also insure the needless interruption of your ongoing medication and it's benefit to your care.

C. Fee For Service

1. **Current Fee Schedule: (15 min = \$75.00) (30 min = \$150.00) (60 min = \$300.00)**
 We reserve the right to charge for other necessary services which are not covered by your Insurance. EX: Letters for Court, Work or Disability Forms; charges for these services will be discussed with you before these services are rendered.
NOTE: A List of Insurance Plans that we are currently contracted with, can/will be provided to you upon request.
2. **Insured/On Covered Insurance Panel:** It is your responsibility to know your benefits and coverage limitations and to confirm applicable and appropriate authorizations for care prior to services being rendered. If you are a member of a participating Insurance panel; it will be your responsibility to pay the co-payment and the deductible, until it is met; both are due at date of service. We will bill your Insurance for Balance Due.
3. **Cash Pay/Not on Covered Insurance Panel:** Full payment is due at the date of service. You may request a Statement/Superbill to submit to your insurer for partial reimbursement. Our office is not responsible for any billing issues with non contracted insurance panels.
4. **Patient Responsibilities:** Patients/Guardians are ultimately responsible for the timely payment of services, regardless of whether or not the patient is covered by a health plan. Account balances are due within 30 days of notification to you that a balance is due, from 1) on the date you receive your EOB/The Explanation of Benefits that your Insurance mails to you monthly; or 2) our office, in the form of a bill, statement, or other written or verbal notification. Any "Outstanding" account balance that is not paid by the due date will be assessed interest. An Outstanding Account Balance sent to a Collection Agency will also incur a Collection Handling Fee of \$75.00 and Interest will continue to accrue until the balance is Paid in Full.
5. **Leaving/Termination From Practice:** Even though you have left the practice, you remain responsible for payment in full of your Entire Outstanding Bill.

Signature of Patient or Responsible Party

Date