PCA
Psychiatric and Counseling Associates

Brent Menninger, M.D.
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Diane Gaunt, APRN
K. Bryce Jones, LCMFT

Patient Registration Form

Name: _____ Social Security Number: _____

Preferred Name: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Main Phone: (_____) _____ Secondary Phone: (_____) _____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed ☐ Legally Separated

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: (_____) _____

(For Patients Under 18)

Mother's Name: _____ Mother's Phone: ___ _____

Father's Name: _____ Father's Phone: _____

Guardian's Name & Phone (If patient does not reside with mother or father): _____

Responsible Party Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Main Phone: (_____)_____ Secondary Phone: (_____)_____

Social Security Number: _____ Date of Birth: _____

Insurance Information

A copy of your insurance card is required, or you will be a self-pay patient. We do require all fields to be filled out, as our billing is off-site. Please note that we do not file to secondary or tertiary insurances, Medicaid, or Medicare

Insurance Company Name: _____ Insurance Phone Number: (_____) _____

Member ID # _____ Group Number: _____

Subscriber Name: _____ Subscriber Social Security Number: _____

Subscriber's Date of Birth: _____ Subscriber's Phone Number: (_____) _____

Subscriber's Employer: _____ Relationship to Patient: _____

PCA Financial Policies

The following is a statement of our Financial Polices which we require you to read, initial by each statement, and sign prior to receiving any treatment from our providers:

_____ (**A**) Thank you for choosing Psychiatric and Counseling Associates, LLC for your care. Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between **you and your insurance company**. It is your responsibility to know your insurance policy benefits. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance, or other matters regarding reimbursement.

_____ (**B**) As a courtesy, we will verify and submit your insurance claim to a primary insurance plan only. We do not bill to secondary or tertiary plans. Please be aware that some, and perhaps all of the services provided, may be non-covered services and not considered reasonable and necessary under your insurance plan. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted with. **You are responsible for providing this office with copies of your insurance card or any changes with your insurance or coverage prior to being seen by one of our providers.** Failure to do so may result in a denial of your claim, making you financially responsible for your session(s). If you do not have insurance, we offer a discounted rate, due at the time of service.

_____ (**C**) You will be charged for every scheduled appointment that is not cancelled at least **24-hours in advance.** Late cancellations or no shows will be billed at a rate of $50.00 for a medication check with a nurse practitioner, $65.00 for a medication check with a psychiatrist, and $80.00 for therapy. Insurance companies will not pay for no shows or late cancellation charges. Payment must be made prior to rescheduling another appointment.

_____ (**D**) We will attempt to make a **courtesy** reminder call, text, and/or email 48-hours prior to your scheduled appointment. Ultimately, keeping scheduled appointment is your responsibility, and if the automatic system fails, you will still be responsible for making your appointment.

_____ (**E**) There is a $45.00 fee for any check returned unpaid by your bank. Your account will then be placed on a cash or credit card only basis, as we will no longer accept checks from you. You will have 10 days to clear up the outstanding check, otherwise it will be sent to our collection agency.

_____ (**F**) We accept cash, checks, all major credit/debit cards, and recommend keeping your credit card on-file. Any outstanding balances are due within 30 days of the statement, after which a $5.00 billing fee will be added to your account. If you experience circumstances beyond your control, please speak with the billing department for payment arrangements. All balances reaching 90-days past due may be sent to our collection agency. You will be financially responsible for all collection and legal fees that our office incurs through the process utilized to collect the delinquent balance. Please be aware if your past due status is reported to a collection agency and/or a credit reporting agency, the fact that you received treatment at our office may be a matter of public record.

_____ (**G**) There may be times when you need medical records, paperwork, or prescription refills completed by one of our providers. There is a fee for filling out and completing these requests or writing prescriptions outside of an appointment. The fees vary according to the document(s) or prescriptions needed. Please allow up to 30 days for medical record requests, 10 days for paperwork to be filled out, and 3 days for prescription refill requests.

_____ (**H**) If you have been, or are now involved in a divorce, please understand that we are legally not part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree. A legal guardian is **required** to be present at all appointments for minor children.

_____ (**I**) We reserve the right to terminate care from this practice for any reason deemed appropriate by your clinician. If at any time you are terminated, balances are due immediately, future appointments will be canceled, and medications will only be prescribed for an emergency within 30-days of the termination date.

I, _____, have read PCA's financial policies and agree to the terms and conditions set forth.
(Patient Name or Guarantor Responsible for Minor)

Patient or Responsible Party Signature: _____ Date: _____

Street Address of Responsible Party: _____

City: _____ State: _____ Zip Code: _____

Phone Number of Responsible Party: (_____) _____ Date of Birth of Responsible Party: _____

Responsible Party's Social Security #: _____

Consent for Treatment

I hereby voluntarily consent to receive services, which may include assessment, and referral recommendations deemed necessary and advisable in the judgment of Psychiatric & Counseling Associates, LLC. If the patient is a minor or otherwise incapable of providing consent, I hereby authorize and consent to the same services for him/her. I understand that the information given to Psychiatric & Counseling Associates, LLC., will be kept confidential and will only be released when: a written consent is obtained, a medical emergency occurs, a court order or subpoena is received, information is required by the insurance company and/or manage care firm to process claims and manage treatment, or a patient represents a serious danger to himself/herself or others. I hereby hold harmless Psychiatric & Counseling Associates, LLC., for any loss, costs, and damages allegedly sustained by me or my ward because of the release of information under the circumstances listed above.

Signature of Patient or Responsible Party: _____ Date: _____

Printed Name of Patient or Responsible Party: _____

Appointment Reminders

My preference for *automated appointment reminders* is: (**Check One)**

_____ Voice Call to Main Phone _____ Voice Call to Secondary Phone

_____ Text Message to Main Phone _____ Text Message to Secondary Phone

_____ **I decline Appointments Reminders**

I would also like *automated appointment reminders* to be sent to my email address: _____ Yes _____ No

Email Address for Appointment Reminders: _____

**** I understand that these appointment reminders are courtesy only. If I fail to attend my scheduled appointment, I am responsible for all missed appointment or billing fees that may incur. I am ultimately responsible for remembering my scheduled appointment. ****

Patient/Guardian Signature: _____ Date: _____

Consent to Leave Messages

I give my consent for PCA clinicians and staff to leave messages regarding scheduling, treatment, lab results, billing, or other information as necessary. (**Check all that apply)**

_____ On the primary answering machine or voicemail _____ On the secondary answering machine or voicemail

_____With a specific individual: _____ _____ Any email provided to us

_____ **I do not consent to messages being left. I wish to be contacted DIRECTLY**

Patient Name: _____ Patient/Guardian Signature: _____

Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

To Our Patients:
Our office holds all your health information confidential. We are required, by law, to keep your health information private and provide you with this Notice of Privacy Practices. This Notice of Privacy Practice explains how Psychiatric and Counseling Associates, LLC (PCA) and its clinical staff and employees may share your Protected Health Information (PHI) with others for treatment, payment, health care operations, and other purposes allowed or required by law. This Notice of Privacy Practices is posted on our web site (www.pca4u.com) and is also available at the front check-in location.

Protected Health Information (PHI) is information about a patient's age, race, sex, and other personal health information that may identify the patient. The information relates to the patient's physical or mental health in the past, present, or future, and to the care, treatment, and services needed by a patient because of his or her health.

Healthcare Operations include activities such as discussions between PCA staff and other health care providers, training clinic staff, interacting with insurance companies, carrying out medical reviews to measure quality, and managing business functions. PCA uses medical records to record health information, to plan care and treatment, and to carry out routine health care functions. Examples of which are listed below:

- Provide PHI to referring providers to create and carry out a plan for your treatment.
- Provide PHI to your insurance company to file claims for payment.
- May use PHI to review the quality of services you receive.
- May send you reminders for appointments.
- May share PHI with public health agencies as permitted by law.
- Will use and disclose PHI when required by federal or state law, or by court order. For example, to investigate reports of abuse.
- May use and disclose PHI for public benefits under other government programs.
- May disclose PHI to law enforcement in order to avoid serious threat to the health safety of a person or the public.
- May disclose PHI to your family or other persons who are officially involved in your medical care. You have the right to object to the sharing of this information.

To release patient PHI to other people for any reason other than treatment, payment, and health care operations (described above) or as required or permitted by law, we must have a permission form known as an Authorization Form signed by the patient or the patient's parent or legal guardian. This form clearly authorizes how you (the patient) wish the information to be used and disclosed.

Your Rights Regarding Your Health Information

Right to see and get copies of your records. In most cases, you have the right to review or get copies of your records. You must make the request in writing. You may be charged a fee for the cost of copying your records.

Right to request a correction or update to your records. You may ask PCA to change (amend) or add missing information to your records if you think there is as mistake. Your request must be made in writing to the Office Manager. In certain cases, we may deny your request for change.

Right to get a list of disclosures. You have a right to ask PCA for a list of disclosure(s) made after April 14, 2003. This is a list of the disclosures we made of medical information about you, other than for treatment, payment or healthcare operations as described in the Privacy Notice. We are not required to account for information releases: that you requested, that you agreed to by signing an Authorization Form, that are given to family or friends involved in your care or certain releases we are allowed to make without your permission. The request for a record must be made in writing to the Office Manager. The request should state the time period for the list. Requests for records about PCA disclosures of your PHI are limited to time frames of six years or less as require by law.

Right to request limits on uses or disclosures of PHI. You have the right to ask that PCA limit how your information is used or disclosed for the purposes of treatment, payment, and healthcare operations. You must make the request in writing telling PCA what information you want to limit and to whom you want the limits to apply. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. If you have paid for your treatment completely out of pocket, you can request for PCA not to provide information about your treatment to your insurance company.

Right to revoke permission. If you are asked to sign an authorization to use or disclose information, you can cancel that authorization at any time. You must make the request in writing. This will not affect information that has already been shared.

Right to choose how we communicate with you. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must request in writing to the Office Manager. Your request must specify how or where you wish to be contacted. We will not ask you the reason for the request. We will attempt to accommodate all reasonable requests.

Right to get a paper copy of this notice. You have the right to ask for a paper copy of this notice at any time.

Complaints: You may submit any complaints with respect to violations of your privacy rights to the PCA Office Manager. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services if you feel that your rights have been violated. There will be no retaliation from PCA for making a complaint.

Change to this Notice: If we make a material change to this Notice, we will provide a revised Notice available at www.pca4u.com.

Contact Information: Unless otherwise specified, to exercise any of the rights described in this Notice, for more information, or to file a complaint, please contact the Office Manager at 913-327-7505.

Patient Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy will be posted in the practice's office, and that a copy of any amended Notice of Privacy Practices will be available at each appointment.

Patient Name: _____

Patient Signature: _____ Date: _____

Parent/Guardian Name (If patient is under 18): _____

Parent/Guardian Signature: _____ Date: _____

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), a federal law, requires that we provide you with this notice that explains our privacy procedures with regard to your medical information and how we may use and disclose your Protected Health Information (PHI) for treatment, payment, and for care operations, as well as purposes that are permitted or required by law. You have certain rights regarding the privacy or your PHI, and we also describe them in this notice.

Coordination of Care Between Healthcare Providers

Communication between behavior health providers and your primary care physician is important to make sure you receive comprehensive and quality care. This form will allow your behavior health provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. PHI may include your diagnosis, treatment plan, progress notes, and medications.

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, mental health, and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives this request. This consent does not expire unless a request to revoke my consent is given.

PCA is authorized to release PHI related to evaluation and treatment of

_____ To: _____

(Patient Name) (Primary Care Physician)

_____ Date: _____

(Patient/Guardian Signature)

8400 W. 110TH ST., STE. 250 | OVERLAND PARK, KS 66210
Phone: (913) 327-7505 | Fax: (913) 327-7054
Website: www.pca4u.com

Medical Information Sheet

Patient Name: _____ Date of Birth: _____

Reason for Visit: _____ Referred By: _____

Occupation: _____ Employer/School: _____

Family Members in Household: _____

_____

Medication Allergies: _____

Date of your last physical examination: _____

Name of your Primary Care Physician (PCP): _____

Do you have or have you had any of the following:

Condition	Yes	No	Please Explain
Heart Problems			
Neurological Problems (Numbness, weakness, headaches, paralysis			
Seizures			

Have you had previous out-patient mental health treatment? If yes, please let us know when and where: _____

_____

Have you been an in-patient at a hospital/institution for psychiatric treatment? If yes, please let us know the reason for admission, location and the date(s) of your treatment.:

_____

_____

Current Medications (include prescriptive, herbal and over-the-counter medications)

Name	Dosage & Frequency	Dates of Use	Prescribing Physician

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Past Psychiatric Medications

Please review the following list of commonly prescribed psychotropics. Both the trade names and generic names are provided in an effort to aid in your recall. Please **check** all that you have been on in the past:

Antidepressants:

- ◯ Prozac/fluoxetine
- ◯ Lexapro/escitalopram
- ◯ Paxil/paroxetine
- ◯ Zoloft/sertraline
- ◯ Celexa/citalopram
- ◯ Luvox/fluvoxamine
- ◯ Wellbutrin/bupropion
- ◯ Serzone/nefazodone
- ◯ Effexor/venlafaxine
- ◯ Remeron/mirtazapine
- ◯ Cymbalta/duloxetine
- ◯ Viibryd/vilazodone
- ◯ Trintellix/vortioxetine
- ◯ Fetzima/levomilnacipran
- ◯ Pristiq/desvenlafaxine
- ◯ Elavil/amitriptyline
- ◯ Anafranil/clomipramine
- ◯ Sinequan/doxepin
- ◯ Tofranil/imipramine
- ◯ Norpramin/desipramine
- ◯ Pamelor/nortriptyline
- ◯ Nardil/phenelzine
- ◯ Parnate/ tranylcypromine
- ◯ Eldepryl/selegiline
- ◯ Ensam patch/equanil

Antipsychotics:

- ◯ Risperdal/risperidone
- ◯ Zyprexa/olanzapine
- ◯ Seroquel/quetiapine
- ◯ Geodon/ziprasidone
- ◯ Abilify/aripiprazole
- ◯ Latuda/lurasindone
- ◯ Fanapt/iloperidone
- ◯ Saphris/asensaprine
- ◯ Rexulti/brexpiprazole
- ◯ Vraylar/cariprazine
- ◯ Invega/paliperidone
- ◯ Thorazine/chlorpromazine
- ◯ Mellaril/thioridazine
- ◯ Prolixen/fluphenazine
- ◯ Trilafon/perphenazine
- ◯ Stelazine/trifluoperazine
- ◯ Haldol/haloperidol
- ◯ Navan/thiothixene
- ◯ Loxitane/loxapine
- ◯ Moban/molindone
- ◯ Clozaril/clozapine

Memory:

- ◯ Exelon/rivastiqmine
- ◯ Reminyl/qalantamine
- ◯ Aricept/donepezil

ADHD:

- ◯ Strattera/atomoxetine
- ◯ Intuniv/Tenex/guanfacine
- ◯ Kapvay/catapres/clonidine
- ◯ Ritalin/Concerta/Metadate/ Daytrana/ Aptensio/Focalin/ Focalin XR/Quillivant/ Quillichew/Ritalin LA/ (methylphenidate products)
- ◯ Adderall/Adderall XR/ Vyvanse/Dexedrine/Adzenys/ Dynavel/Zenzedi/Mydayis dextroamphetamine
- ◯ Cylert/pemoline

Mood Stabilizers:

- ◯ Eskalith/Lithobid/lithium
- ◯ Depakote/divalproex
- ◯ Tegretol/Carbatrol/ carbamazepine
- ◯ Lamictal/lamotrigine
- ◯ Trileptal/oxcarbazepine
- ◯ Keppra/levetiracetam
- ◯ Topamax/topiramate
- ◯ Gabitril/tiagabine
- ◯ Neurontin/gabapentin

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Anti-Anxiety:

- ◯ Inderal/propanolol
- ◯ Lopressor/metoprolol
- ◯ Tenormin/atenolol
- ◯ Buspar/buspirone
- ◯ Atarax/Vistoril/ hydroxyzine
- ◯ Klonopin/clonazepam
- ◯ Ativan/lorazepam
- ◯ Xanax/alprazolam
- ◯ Valium/diazepam
- ◯ Serax/olazepam
- ◯ Librium/chlordiazepoxide
- ◯ Tranxene/clorazepate

Sleep Aides:

- ◯ Miltown/meprobamate
- ◯ Desrel/trazodone
- ◯ Ambien/zolpidem
- ◯ Sonata/zaleplon
- ◯ Lunesta/eszopiclone
- ◯ Somnote/chloral hydrate
- ◯ Restoril/temazepam
- ◯ Halcion/triazolam
- ◯ Prosom/estazolam
- ◯ Dalmane/flurazepam
- ◯ Rozerem/ramelteon
- ◯ Silenor/doxepin
- ◯ Belsomra/suvorexant

Patient/Guardian Signature: _____ Date: _____

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CREDIT CARD ON-FILE POLICY

- Psychiatric & Counseling Associates recommends keeping your credit or debit card on-file as a convenient method of payment for any balances that are patient responsibility, as well as for any refunds if insurance pays more than anticipated. Your credit card information is kept confidential and secure. Whenever a payment is processed you will receive a credit card receipt by email if you choose. If you decide not to keep your credit card on-file, statements are sent monthly, and your first statement is mailed at no charge. If a second statement is required to settle the account, a billing fee of $5 will be added to your account.
- If you have questions or concerns regarding your options please contact our Billing Manager, Sarah Rostan at billing@pca4u.com or 913-327-7505, opt 2.

Amex Visa MasterCard Discover

Credit Card Number _____

Expiration Date _____ / _____ / _____ **Security Code (CVV)** _____

Cardholder Name _____

Signature _____

Email _____

Billing Zip _____

- I (we), the undersigned, authorize and request Psychiatric & Counseling Associates to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility, or other self-pay balances that incur on the account. This authorization relates to all payments not covered by my insurance company for services provided to me by Psychiatric & Counseling Associates. This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 30-day notification to Psychiatric & Counseling Associates in writing.

Patient Name (Print): _____

Additional Patient Account(s) this applies to: _____

Patient or Cardholder Signature: _____ Date: _____

Decline Credit Card on File

I, _____, decline to keep my credit card on file, and understand that any balance over 30 days past due will incur an additional $5.00 charge for our office to continue collection efforts.

Patient or Guarantor Signature: _____ Date: _____