**EMPOWER MENTAL HEALTH**
SUSAN CLAVETTE, APRN ,BC
MAKENZIE BICKERS, APRN, BC
DEB BAKER, MS, SEP, ODRM
7171 W 95th St, Suite 210 Overland Park, KS 66212
913-210-6005; FAX 913-210-6008
office@empowerkc.com

## GENERAL INFORMATION

FULL NAME: _____ PHONE NUMBER: _____
ADDRESS: _____CITY/STATE/ZIP:_____
DOB: _____ GENDER: ____F: ____M ___OTHER: MARITAL STATUS: ___S: ___M: ___D: ___W
HOW DID YOU HEAR ABOUT US? _____E-MAIL: _____
PHARMACY: _____ PHONE NUMBER: _____
EMPLOYMENT STATUS: ____ FT/PT employed: ___ FT student: ___ Retired: ___Disability: ___ Not employed
OCCUPATION: _____ EMPLOYER: _____
EMERGENCY CONTACT/NUMBER: _____OK to contact in case of an emergency? ___

## PLEASE CHECK ANY/ALL THAT APPLIES
## WHY ARE YOU HERE?

_____ I am in crisis
_____ I need advice on a specific problem
_____ It would help me to talk to someone
_____ I need a question answered
_____ I need testing
_____ I need medication to help the way I feel
_____ It's not me who has the problem; I'm here because someone else sent me
_____ Other: _____

### WHAT IS GOING WELL IN YOUR LIFE?

_____
_____

## SUBSTANCE ABUSE HISTORY

Current use or use in pregnancy? __YES __NO:Past use of drugs &/or alcohol? ___YES ___NO; if yes, specify:
Caffeine:_____
Tobacco: _____
Alcohol:_____
Marijuana: _____
Other:_____
_____

TREATMENT FOR ALCOHOL/DRUG ABUSE: list locations, dates of treatment, duration

In-patient Detox: _____
Long-term residential: _____
Out-patient treatment: _____
AA/NA: _____
Longest period of sobriety: _____ Legal problems related to drug/alcohol use: _____
Withdrawal symptoms/medical problems from drug/alcohol use: _____
Loss of a job, child custody, relationship due to drug/alcohol use: _____

## PRIMARY INSURANCE

(Do not need to complete if we have your insurance card)

Insurance company:_____
Patient's relationship to policy holder/subscriber: _____
Full legal name of policy holder/subscriber: _____
*Policy holder DOB: _____ * Policy holder SS#: _____
Address (if different from patient's): _____
Phone number (if different from patient's): _____
Employer: _____
*this information is needed for us to file your insurance

## ADDITIONAL INSURANCE

Is the patient covered by additional insurance: _____YES: _____ NO:
Insurance company: _____
Patient's relationship to policy holder/subscriber: _____
Full legal name of policy holder/subscriber: _____
DOB: _____ SS #: _____ Phone number (if different): _____
Address (if different): _____
Employer: _____

## ASSIGNMENT AND RELEASE

I certify that I (or my dependent) have insurance coverage with _____ and directly assign to Empower Mental Health (Susan Clavette Integrative Psychiatric NP, LLC) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, regardless if paid by my insurance company(ies). I hereby authorize the release of all information necessary to my insurance company(ies) to secure the payment of benefits. I authorize the use of this signature on all insurance claim submissions.

X_____
patient/responsible party signature date

_____
printed name of the responsible party, if not patient relationship to patient

# EMPOWER MENTAL HEALTH

7171 W 95th St. Suite 210 Overland Park, KS 66212 913-210-6005; FAX 913-210-6008
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NAME: _____

## NOTICE OF PRIVACY PRACTICES

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

### PURPOSE

EMPOWER MENTAL HEALTH**,** professional staff, employees, and trainees follow the privacy practices described in this notice. We keep your mental health information in records that will be maintained and protected in a confidential manner, as required by law. Please note that to provide you with the best possible care and treatment, all professional staff involved in your treatment and employees involved in the healthcare operations have access to your records.

### WHAT ARE TREATMENT AND HEALTH CARE OPTIONS?

Your treatment includes sharing information among mental health care providers who are involved in your treatment. Treatment records may be reviewed as part of an ongoing process to ensure the quality of operations.

### HOW WILL MY PROTECTED HEALTH INFORMATION BE USED?

Your personal mental health records will be retained by us for approximately 10 years after your last clinical contact. After that time has elapsed, the records will be shredded or otherwise destroyed in a way that protects your privacy. Until the records are destroyed, they may be used, unless you ask for restrictions on a specific use or disclosure, for the following purposes:

- Appointment reminders
- Notification when an appointment is canceled or rescheduled
- As may be required by law
- For public health purposes, such as reporting child or elder abuse/neglect; reporting medication reactions; infection/disease control; notifying authorities of suspected abuse, neglect, or domestic violence (if you agree or as required by law)
- Mental health oversight activities, such as audits, inspections, or investigations of administration and management
- Lawsuits and disputes: We will attempt to provide you with advance notice of a subpoena before disclosing information from your record.
- Law enforcement (such as in response to a court order or other legal process) to identify or locate any individuals being sought by authorities about a victim of a crime under restricted circumstances, about a death that may result from criminal conduct, about criminal conduct that occurs in the office; when an emergency circumstance occurs relating to a crime
- To prevent a serious threat to health or safety
- To carry out treatment and health care operations through medical transcription services
- To military compound authorities if you are a member of the armed forces or a member of a foreign military authority
- Protection of the President or other authorized persons for foreign heads of the state or to conduct special investigations
- Alcohol and drug abuse information has special privacy protections; we will disclose limited information about alcohol and drug abuse. Otherwise, we will not disclose any mental health or medical information relating to a patient's substance treatment unless 1) The patient consents in writing, 2) A court order requires disclosure of the

information, 3) Medical personnel need the information for a medical emergency: 4) Qualified personnel use the information for the purpose of conducting research, management audits, or program evaluation: or 5) It is necessary to report a crime or a threat to commit a crime or to report abuse or neglect as required by law.

## YOUR AUTHORIZATION IS REQUIRED FOR OTHER DISCLOSURES

Except as previously described, we will not disclose or use information from your record unless you authorize our office in writing to do so. You may revoke your permission, which will be effective only after the date of your written revocation.

## YOU HAVE RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

You have the following rights regarding your health information, provided that you make a written request to invoke the right.

- Right to request restriction. You may request limitations on your mental health information we may disclose, but we are not required to agree to your request. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Right to confidential communications. You may request communications in a certain way or at a certain location, but you must specify how or where you wish to be contacted.
- Right to inspect and copy. You have the right to inspect and copy your mental health information regarding decisions about your care; however, psychotherapy notes may not be inspected and copied. We may charge a fee for copying, mailing, or supplies. Under limited circumstances, your request may be denied; you may request a review of the denial by another licensed mental health professional chosen by our office. Our office will comply with the outcome of the review.
- Right to request clarification of record. If you believe that the information about you is incorrect or incomplete, you may ask to add clarifying information. Right to accounting or disclosures: you may request a list of the disclosures of your mental health information that may have been made to persons or entities other than for treatment or health care operations in the last six (6) years but not before March 16, 2017 (disclosures before March 16, 2017, do not have to be made available).
- Right to a copy of this Notice. You may request a paper copy of this notice at any time.

## REQUIREMENTS REGARDING THIS NOTICE

We are required to provide you with this Notice that governs our privacy practices. Our practice may change its policies and procedures regarding privacy practices. If and when changes occur, the changes will be effective for the mental health information we have about you and any information we receive in the future. Any time you come in for an appointment, you may ask for and receive a copy of the Privacy Notice that is in effect at the time. This notice became effective on March 16, 2017.

## CONCERNS:

If you believe your privacy rights have been violated, you may file a written complaint with our office manager.
You may also send a written complaint to the Secretary of the US Department of Health and Human Services. You will not be penalized or retaliated against in any way for filing a complaint.

## PLEASE COMPLETE THE FOLLOWING:

- May we phone, email, or text you to confirm your appointment? YES. NO
- May we leave a message on your voicemail at home or on your cell phone? YES. NO
    - I give my consent to receive and send text messages, understanding that text messages, voice mails, and emails are not secure (you may opt out of this service at any time) YES. NO

**Signature of patient or legal guardian**

**X**

**Print patient's name** **Date**

**Print name of legal guardian** **Date**

UPDATED 12/23

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## MEDICAL HISTORY

Please circle any of the following health problems that you have currently, or have been diagnosed with:

Asthma, COPD, bronchitis
Diabetes
Chronic pain _____
STD _____
Headaches, visual changes
GI symptoms: diarrhea, constipation
Cancer, type: _____
HTN, heart disease, high cholesterol
TBI, seizures, loss of consciousness
Autoimmune diseases, lupus, thyroid
Night sweats
Recent falls, numbness.tingling in extremities
Other: please identify all other health conditions that you are being treated for: _____

_____

Primary Care Provider: _____

Last Physical Exam: _____. EKG: (indicate if abnormal): _____

Children and Adolescents-immunizations current? _____

Previous surgeries: NO YES (if yes, please list):
_____

Are you allergic to any medications: NO YES (if yes, please list all medication allergies and reaction):
_____
_____

Female patients: Pregnant? NO YES Birth control method: _____

Please list all current medications, including OTCs, Vitamin, Supplements:

MEDICATION- Dose-Frequency-Who prescribing?
_____

_____

_____

_____

_____

_____

_____

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## PRACTICE POLICIES & PROCEDURES

**NAME:** _____

We thank you for choosing us and look forward to working with you. We strive to provide the very best care to you; in order to do so, we would like to take this opportunity to inform you of our policies and procedures.

**APPOINTMENTS:**
We ask that you make appointments as recommended by your provider. If you are unable to keep your appointment, please give us **24 HOURS NOTICE**; failure to do so will result in a **LATE CANCELLATION FEE OF  $75.00**, as determined by your provider. This also applies to **no-show appointments;** these fees must be paid before another appointment is scheduled. Please understand that appointments that are late cancels and/or no-shows do not allow us adequate time to fill these appointment times. Consistently missed appointments may result in the termination of your continuance with our practice and is up to the provider's discretion. We will attempt to confirm appointments beforehand, but this is a courtesy service to you and should not be depended upon. If you are more than 15 minutes late and have made no attempt to notify us of your late arrival, you may be asked to reschedule.

**PRESCRIPTIONS:**
You may request needed renewed prescriptions at the time of your appointment. REFILLS ARE DONE DURING OFFICE HOURS ONLY AND ARE NOT CONSIDERED AN EMERGENCY OR A CRISIS SITUATION. In most cases, we ask that you contact the office and not your pharmacy.  Please understand that if you have NOT scheduled a follow-up appointment, your refill request may be denied. All controlled substance medications (Adderall, Vyvanse, Ativan, etc.) require an e-RX prescription; this will be discussed and reviewed during your appointment. Lost or stolen medication will not be replaced unless you have filed and provided a copy of a police report. **ALL SCHEDULED MEDICATIONS/CONTROLLED SUBSTANCES WILL NOT BE FILLED EARLY.** Unless discussed with your provider beforehand, NO NEW medications will be provided by telephone request. We value quality of care and safety, and in order to maintain this standard, it is impossible to adequately assess, diagnose, and prescribe new medication changes over the phone. THERE WILL BE NO 90-DAY RX FOR ANY CONTROLLED SUBSTANCE DUE TO DEA REGULATIONS.  IF YOU HAVE NOT BEEN SEEN DURING THE SPECIFIED TIME, YOU WILL NOT RECEIVE ANY ADDITIONAL FILLS, AND IT IS RECOMMENDED THAT YOU MANAGE ANY REMAINING MEDICATION TO GET YOU TO YOUR NEXT APPOINTMENT.

**INSURANCE:**
In order for us to file your insurance claim for you, we need a copy of your insurance card at the time of your appointment. If you do not have your insurance card with you, we will consider self-pay until we receive a copy. You are responsible for knowing your insurance coverage; referrals and/or authorizations for services, fees for co-pays, deductibles, non-covered services, or self-pay payments are expected at the time of service. For your convenience, we accept cash, debit, or credit cards. Understand that our practice will not become involved in insurance disputes. We do not bill you for fees due at the time of your appointment. It is your responsibility to notify us of any changes to your insurance. You are ultimately responsible for your bill.

**MINOR PATIENTS:**
Patients under the age of 18 must be accompanied by a parent/guardian and accept responsibility for their bill. Prescriptions will not be given to them without the consent of the parent/guardian.

**PAPERWORK/LETTERS:**
ALL paperwork (whether short-term disability, FMLA, etc.) will be completed during an appointment scheduled specifically to complete this paperwork. In order to accurately complete disability and/or FMLA paperwork, a relationship needs to be established with your provider; therefore, such paperwork will NOT be completed at the start of care. We will no longer submit paperwork for emotional support animals or ADA accommodations.

**AFTER-HOURS & GENERAL INFORMATION:**
The after-hours phone number is for **URGENT EMERGENCIES ONLY.** For life-threatening emergencies, please call 911 or go to your nearest emergency room. Please do not call after hours to schedule or change appointments, request refills, or give updates regarding response to treatment and/or questions regarding treatment.

Our practice reserves the right to terminate or discharge any patient at any time due to treatment non-compliance, threatening or abusive behavior, failure to follow office policies and procedures, failure to meet financial obligations, or failure to keep scheduled appointments. Please understand that if you terminate care with this office, medication refills will not be provided, and we advise that you establish care with another provider as quickly as possible.

We are committed to providing the best possible care. By signing this form, you have a clear understanding of our policies and procedures and agree to adhere to them. A copy of this form is available upon your request. Please ask if you have any questions. This form must be signed before you can be seen in this office. Thank you for your cooperation.

**I HAVE READ AND AGREE TO ALL OF THE ABOVE POLICIES AND PROCEDURES**

Patient/guardian signature: X_____
Date: _____

Update 12/23

# TELEHEALTH

Telehealth is a form of video conferencing that allows our providers to provide services to patients outside of the office, for example, to the patient's home. Telehealth provides the patient with benefits that may lead to better care since it can be challenging to take time from work to come to the office. For patients who are usually seen in the office but are sick or there are weather concerns, this form of treatment allows you to keep your appointment without interrupting your care.

For your telehealth appointment, the patient needs access to a private place, a smartphone or laptop with a camera, and internet access. This office ensures that the interaction between our patients and providers is completely secure and HIPAA compliant. Our teleconferencing platform encrypts all forms of data, including video and audio.

Telehealth is increasing, now more than ever, because it makes healthcare more accessible. If you are interested in scheduling a telehealth appointment, please speak with your provider or the office staff.

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## TELEHEALTH CONSENT FORM

PATIENT NAME: _____

1. I understand that my practitioner wishes me to engage in a telehealth consultation.

2. My practitioner has explained to me how the video conferencing technology will be used to affect such a consultation and will not be the same as a direct patient/practitioner visit since I will not be in the same room as my practitioner.

3. I understand that a telehealth visit has potential benefits, including easier access to care and the convenience of meeting from a location of my choosing.

4. I understand that there are potential risks to this technology, including interruptions, unauthorized access, and/or technical difficulties. I understand that my practitioner or I can discontinue the telehealth visit if it is felt that the video-conferencing connections are not adequate for the situation. To maintain confidentiality, a link will be sent to me at my scheduled appointment time, and it is recommended not to share this link with anyone unauthorized to attend the appointment.

5. I understand that my healthcare information may be shared with other staff for scheduling and billing purposes. I have had the alternatives to a telehealth visit explained to me, and I am choosing to participate in a telehealth visit.

6. I understand that billing will occur for the visit.

7. I have had direct conversations with my provider, during which I had the opportunity to ask questions. My questions have been answered, and the risk vs. benefit and any practical alternatives have been discussed with me in a language I understand.

8. Telehealth visits are not intended to provide emergency services, and in the event of an emergency, I will call 911 or go to the nearest emergency room.

By signing this form, I certify:

That I have read and/or had this form explained to me.

That I fully understand its contents, including the risks vs. benefits of the procedure(s).

That I have been given ample opportunity to ask questions, and that my questions have been answered.

_____ _____

Patient signature  Date