

# LIFE MANAGEMENT FOR ADULTS, PLLC

## NEW PATIENT REGISTRATION

Today's Date: \_\_\_\_\_

### PATIENT INFORMATION

First Name:	Last Name:	
Date of Birth:	Sex: -	Marital Status: -
Home Address:		
City:	State:	Zip Code:
Email:		
Cell #	Home #	Work #

Who is financially responsible?  Self  Other \*\*

**\*\*BILLING CONTACT – Statements will be mailed to patient if left blank.**

Name:		
Home Address:		
City:	State:	Zip Code:
Email:		
Cell #	Home #	Work #

### EMERGENCY CONTACT

#### Relationship to Patient (check all that apply):

Name:	<input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> DPOA <input type="checkbox"/> Guardian	
Home Address:	<input type="checkbox"/> Other (please describe)	
City:	State:	Zip Code:
Email:		
Cell #	Home #	Work #

Is there a DPOA or Guardian?  No  Yes \*\*(if yes, please provide a copy for our records.)

### DPOA / GUARDIAN

#### Relationship to Patient (check all that apply):

Name:	<input type="checkbox"/> Spouse/Partner <input type="checkbox"/> Child <input type="checkbox"/> DPOA <input type="checkbox"/> Guardian	
Home Address:	<input type="checkbox"/> Other (please describe)	
City:	State:	Zip Code:
Email:		
Cell #	Home #	Work #

**PRIMARY INSURANCE INFORMATION**

Name of Insurance Plan:

Effective Date:

Policyholder Name:

Date of Birth:

Member ID#

Copay \$

Group#

Deductible \$

Relationship to Policyholder:

 Self Spouse/Partner Child Other

Employer Name

**\*COPY OF CARD REQUIRED (front and back)****SECONDARY INSURANCE INFORMATION**

Name of Insurance Plan:

Effective Date:

Policyholder Name:

Date of Birth:

Member ID#

Copay \$

Group#

Deductible \$

Relationship to Policyholder:

 Self Spouse/Partner Child Other

Employer Name

**\*COPY OF CARD REQUIRED (front and back)**

# MEDICAL HISTORY

Today's Date \_\_\_\_\_

A Release Form (Patient Authorization to Disclose PHI) must be completed for any person, facility, or provider for which you would like LMA to receive or share information.

If you have had any lab work or an EKG in the last 12 months, please have your records sent to our office prior to your appointment. Records can be faxed to 888.499.1213.

**Patient Name**

**Date of Birth**

**LOCAL Pharmacy**

**MAIL ORDER Pharmacy**

Address

Pharmacy Phone #

Pharmacy Phone #

Pharmacy Fax #

Pharmacy Fax #

**Prescription Insurance**

**Member ID#**

RX BIN #

RX PCN #

RX Grp #

**Please list any allergies to medications**

**List Current Medications with dose, instruction and start date**

**Primary Care Physician**

Name of Facility

Office #

Fax #

RELEASE FORM COMPLETED?

**Previous Psychiatrist / Prescriber**

Name of Facility

Office #

Fax #

RELEASE FORM COMPLETED?

**Counselor/Therapist/Other**

Name of Facility

Office #

Fax #

RELEASE FORM COMPLETED?

---

## LIFE MANAGEMENT FOR ADULTS, PLLC

---

### PRIVACY AND CONFIDENTIALITY

This notice describes how your psychological and medical information may be used or disclosed.

Life Management for Adults (LMA) may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations.

LMA may use or disclose PHI for purposes outside of treatment, payment, and healthcare operations when your appropriate authorization is obtained. LMA may ask for your permission to allow contact with your primary care physician, psychotherapist, past psychiatrists or others whose care may interact with your treatment and management. Again, this will be your choice to permit such contact and thus sign an authorization form.

LMA may use or disclose your PHI in unusual circumstances without your consent. LMA will work effectively with every patient to avoid such situations. These circumstances are: 1) when LMA has a reason to suspect that a child has been abused or neglected, 2) when LMA suspects that any incapacitated adult has been subject to abuse, neglect, self neglect or exploitation, or is living in hazardous conditions and, 3) if you have communicated to LMA or when LMA has a reason to believe that you pose a direct threat of imminent harm to any individual (including yourself).

Also, although client-psychiatrist communications are generally protected as confidential under the law, LMA may be required to use or disclose information about you in the course of a judicial or legal proceeding if LMA is ordered by a court to do so. LMA reserves the right to use and disclose information about you if doing so is necessary to defend itself in a legal action brought against it in relation to your care.

Finally, confidentiality of your information is of utmost importance to LMA. LMA believes that this is a critical element in developing the trust and openness essential in the process of addressing mental health issues.

By signing, I acknowledge that I have received and reviewed a copy of this Notice of Privacy Practices.

#### **Electronic Signature of Patient or Legal Representative\***

---

Signer's Printed Name:

Signed Date:

Patient's Full Name:

Date of Birth:

**Acceptance Checkbox \***  *I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.*

---

**SIGN AND RETURN**

---

# Records Release Authorization

## FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I. I authorize my provider: Life Management For Adults Phone: (603) 205-2953  
P.O. Box 969, Portsmouth, NH 03802 Fax: (888) 499-1213

to **RELEASE** information to the **SECOND PARTY**  
as directed below

to **RECEIVE** psychological/psychiatric mental  
health information from the **SECOND PARTY**  
as directed below

2. **SECOND PARTY** Name: \_\_\_\_\_

Full Address: \_\_\_\_\_ Phone #: \_\_\_\_\_

Email: \_\_\_\_\_ Fax #: \_\_\_\_\_

3. **TYPE OF INFORMATION TO BE DISCLOSED** (choose one)

**Complete copy of the medical record.** I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy

I authorize **only the disclosure** of the following information:

4. **PURPOSE** (choose one)

My health information is being disclosed at my request or at the request of my personal representative

My health information is being disclosed for the following purpose:

5. **Note any exclusions or limitations here:** \_\_\_\_\_

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

**Signature:**

**Email:**

\_\_\_\_\_  
*Signature of Patient or Legal Representative\**

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Print Name*

\_\_\_\_\_  
*Relationship to patient*

**Acceptance Checkbox \*** / understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

---

# LIFE MANAGEMENT FOR ADULTS, PLLC

---

## OUTPATIENT SERVICE AGREEMENT

Welcome to Life Management for Adults (LMA). This document contains important information about LMA's professional services and business practices.

### SERVICES

LMA treats adults with various psychiatric problems, including depression, bipolar disorder, anxiety, psychosis, and other mental health issues. At times, it will be difficult for you to specify and verbalize a mental health issue, but sense that you need help for something. LMA will work with you to identify and define such issues and eventually try to overcome them.

LMA provides diagnostic evaluations, medication management and psychotherapy. For clients who are already working with a psychotherapist, LMA will ensure that this will not be a barrier to treatment.

### SESSIONS

An initial evaluation usually lasts 1-2 sessions. During this time, your reason for seeking assistance will be discussed as well as your treatment goals. LMA will work with you in deciding whether this setting is the better fit for you in terms of meeting your goals. The frequency of your follow up visits will depend on the service, clinical need, and insurance company or other financial limits.

### FINANCIAL PSYCHIATRIC FEES (if the client does not have insurance)

Initial Psychiatric Evaluation, 45-60 minutes:	\$400.00 - \$420.00
Follow up, for medication management only	\$170.00 - \$180.00
Follow up for medication management and psychotherapy	\$220.00 - \$230.00

### MISCELLANEOUS FEES

**No Show (not covered by insurance):** \$150.00

*A 24 hour notice is required to cancel, otherwise the above fee will apply.*

**Return check bank fee:** \$25.00

*please initial*

---

### Appointments with Balance owed:

Clients with existing balances will not be given an appointment. However, we do accept credit cards over the telephone or payments can be made on-line at [www.lifemanagementforadults.com](http://www.lifemanagementforadults.com) under the Existing Patient's page. Statements are mailed monthly and accounts should be kept current.

*please initial*

---

LMA operates on a fee-for-service basis. All fees will be due at the beginning of each session. LMA participates in many insurance companies and will submit insurance claims on your behalf. However, please be advised that if an insurance company denies a claim, you will be responsible for the payment according to the fees above. If your account has not been paid for more than 60 days and arrangement for payments have not been agreed upon, LMA has the option of using legal means to secure the payment. This may involve hiring a collection agency which might require LMA to disclose otherwise confidential information.

**INSURANCE:**

Please contact your insurance plan to verify your Behavioral Health and Telehealth Benefits. We are not In Network with all plans, so please be aware of your Out of Network Coverage as well as your Copayment and Deductible.

**HOPSICE** - Insurance will not cover patients once they are on hospice. The patient will be financially responsible at the Self Pay rates.

**NOTE:** You must notify our office of the insurance changes and verify your Behavioral Health Coverage prior to your appointments.

**DISCHARGE**

Clients may be discharged for the following reasons, but not limited to:

1. Failure to comply with signed Service Agreement.
2. Non payment of services: after 3 months. All payments are due in full at time of appointment.
3. If clients miss 3 visits (cancellation due to medical or personal reasons) without 24 hours notice, or 3 no show appointments during the course of treatment, the client will be discharged from the practice.
4. Inappropriate behavior.
5. Inappropriate use of prescription refills

If any of the above apply, you will be allowed a period of 60 days to be seen if appointments are available. We will provide you referrals so you can establish a relationship with another provider.

**LATE ARRIVALS**

Clients who arrive late for appointments disrupt the schedule for other clients. We are committed to staying on schedule for all our clients. Late clients may not be seen that day and may be charged 50% of a no show fee.

*please initial*

---

**OTHER PROFESSIONAL FEES**

LMA charges a general professional fee of \$150.00/hour for other services that you may need. Other services include but are not limited to, writing of reports and letters, consulting with other professionals at your request, prior authorizations for particular medications, preparation of records, treatment summaries or other documentation regarding your treatment, and other services that you may request.

Letters, forms and other necessary requests per patient request will be a minimum of \$25.00. This will depend on the detail and attention required by the physician.

LMA charges professional fees for legal services since it can be arduous, extensive, and even at times complicated.

Attorney Meetings / Material Review \$300.00/hour

Court Testimony / Depositions \$450.00/hour

*please initial*

---

**CANCELLATIONS**

LMA ensures that when you make an appointment, a specified amount of time is reserved for you. If you cancel an appointment, LMA requests its clients to give at least 24 hours notice excluding weekends and holidays. If a client is unable to cancel a scheduled appointment, fees will be charged. (See professional fees above) Please take note that insurance companies do not provide reimbursements for cancelled sessions. This associated fee must be paid prior to rescheduling your next appointment. Repeated missed appointments may necessitate termination of treatment.

Please keep in mind that if you reschedule due to, but not limited to, an illness, hospitalization or transportation, at your request LMA will put you on a wait or cancellation list. However, please understand the next available appointment could be approximately 6-8 weeks.

**COMMUNICATION**

If a client has to contact a physician, please call the office directly and leave a message. The call will be returned within 24 - 48 hours during business hours Monday – Friday between 9:00 am – 3:00 pm. On occasion, calls will be returned evenings and/or weekends. If it is an emergency, please go directly to your local emergency room.

Email will only be used for initial paperwork and billing purposes only. Please do not expect return emails from a physician.

**PRIVACY**

LMA believes that confidentiality is an important component of your treatment. Privacy will make you more comfortable and forthcoming with information, thus a better working relationship. As a rule, LMA will not release any information about you unless you provide specific authorization. For details regarding this matter, please refer to the Privacy and Confidentiality document.

**STATEMENT OF PRINCIPLES**

LMA strives to comply with the advisories and ethical principles of the American Medical Association and the American Psychiatric Association.

**CLIENT AGREEMENT**

I have received the above Outpatient Services Agreement, which describes the services and policies of LMA. I understand that I am encouraged to discuss any questions or concerns that I may have regarding this document. I authorize Life Management for Adults, PLLC to release necessary information to process by insurance claim and authorize payment of insurance directly to LMA, PLLC. I acknowledge that I am responsible for any balance not covered by my insurance company.

**Electronic Signature of Patient or Legal Representative\***

\_\_\_\_\_  
Signer’s Printed Name:

\_\_\_\_\_  
Signed Date:

\_\_\_\_\_  
Patient’s Full Name:

\_\_\_\_\_  
Date of Birth:

**Acceptance Checkbox** \*  *I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.*

**SIGN AND RETURN**

---

# LIFE MANAGEMENT FOR ADULTS, PLLC

---

## TELEHEALTH SERVICES INFORMED CONSENT

### Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

### I understand that I have the rights with respect to telehealth:

1. I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.
2. My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.
3. I understand the potential risks to technology including interruptions, unauthorized access and technical difficulties. I understand my health care provider, or I can discontinue the videoconference consult/visit if it is believed videoconferencing technologies are not adequate for the situation.
4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that no results for anticipated benefit can be guaranteed or assured by my provider.
7. I understand my healthcare information may be shared with other individuals for purposes of scheduling and billing. Individuals others than my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:
  - ask non-medical personnel to leave the telehealth examination room; and/or
  - terminate the consultation at any time.
8. I agree certain situations – such as emergencies and crisis -- are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

### Consent to The Use of Telehealth

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.

### Electronic Signature of Patient or Legal Representative\*

---

Signer's Printed Name: \_\_\_\_\_

Signed Date: \_\_\_\_\_

Patient's Full Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Acceptance Checkbox** \*  *I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.*

---

**SIGN AND RETURN**

---