Lynn Hutchins
Psychiatric Group

POLICIES AND PROCEDURES

PLEASE READ CAREFULLY AND COMPLETE

We welcome you to Lynn Hutchins Psychiatric Nurse Practitioner, PLLC. We prepared the following information so that you may have a clear understanding of our policies and procedures concerning fees, insurance, and confidentiality. We look forward to working with you and getting to know you! It is our goal to provide the best mental health care, as well as making your visits here pleasant, courteous, and as efficient as possible.

Office Hours: Our normal business hours are Monday through Thursday, 8:00 am to 5:00 pm. We are closed for lunch from noon until 1:00 pm. Our Facebook page, Lynn Hutchins Psychiatric, or our voicemail are the best ways to stay updated on closings due to holidays, vacation, or inclement weather. It is important to make sure you have enough medicine to prevent running out when the office is closed. **Please note that the office is always closed for a week during the July 4th holiday and December 24-January 1. Please make sure you have enough medication to last during these periods of time.**

Medical Records, Medical Forms, Letter Fees: All requests for records, forms and letters may take up to 30 days to complete. The completion of forms and letters is a courtesy. To cover the costs incurred in searching, handling and copying records for these requests, a fee for each request shall be:

Medical Records

- Minimum of $10.00 or:
- $0.75 per page for the first 25 pages of medical records
- $0.50 per page for pages 26-100 of medical records
- $0.25 per page for excess of 100 pages of medical records

Medical/Disability Forms

- A minimum of $25.00 or
- $10.00 per page for forms containing more than 3 pages excluding pages to be completed by the patient

Letters (other than appointment confirmation)

- Minimum of $10.00

Telephone Calls: You may contact our office with questions, concerns, or prescription refill requests by calling 252-281-5044 or by emailing us at contact@lynnhutchinspsych.com. All efforts will be made to respond within 1 business day. (Our office hours are Monday-Thursday. For Example: If you call on Monday, we will respond by closing on Tuesday. If you call on Thursday, we respond by closing on Monday.) **In the case of a psychiatric emergency after hours or on weekends,** please call 911 for transport to your nearest emergency room. **NO REFILLS WILL BE GIVEN AFTER HOURS OR ON WEEKENDS.** For non-emergency issues, we ask that you call during regular office hours; otherwise, there will be a $35.00 charge billed to you. Clients of our therapist, Mary Bennett, may occasionally have the need for crisis intervention by phone. Her crisis intervention policy will be discussed on an individual basis.

Appointments: Please allow an extra 30-45 minutes past your scheduled appointment. We attempt to stay as close to your scheduled appointment time as possible, however, some emergency situations may cause you to be seen later than your scheduled appointment.

Please keep and be on time for all scheduled appointments. If you are more than 10 minutes late for your appointment, you may have to reschedule.

If you are unable to keep an appointment, please call our office immediately**. A No-Show Fee will be charged if you have failed to contact our office at least 1 business day prior to your appointment to cancel or reschedule.** Our business days are Monday-Thursday, 8:00 am- 5:00 pm. (i.e.: If you have a Wednesday appointment, you must contact our office before 5:00 pm on Tuesday. If you have a Monday appointment, you must contact our office before 5:00 pm on Thursday.)

Payment: As a courtesy to you, Lynn Hutchins Psychiatric will file office visits with your insurance company. However, payment of all applicable copays, deductibles, co-insurance, or additional fees is required before being seen for your appointment. Also, please bring your current insurance card to all appointments. Payment may be made by cash, check, credit, or debit card. If you do not have your insurance card or full payment, your appointment will be rescheduled.

If a check is returned due to insufficient funds, a processing charge of $25.00 will be charged to your account for the returned check.

Please note that you are ultimately responsible for all charges incurred for your treatment or the treatment of those for whom you are responsible. If for any reason your insurance company, or other third-party payer, does not promptly reimburse Lynn Hutchins Psychiatric for services, you will be responsible for those charges.

Prescription Refills (when applicable): Refills will only be given during office hours, Monday-Thursday, 8:00-5:00. Allow 2 business days for all prescription refills. Stimulant prescriptions must be picked up at the office.

Consent for External Prescription Check: I grant permission to view when and where you are filling your prescriptions from external sources to verify compliance with our controlled substance agreement. I agree to give a blood, saliva, and/or urine sample, if asked, to test for drug use.

Confidentiality: Any confidential information you disclose to us during treatment, or any other confidential information we may obtain, shall be held in confidence unless you permit us to disclose such information in writing or where we are required to disclose such information by law.

By signing this contract, you are agreeing to the disclosure of confidential information where such disclosure is necessary to obtain certification, authorization, or payment for your treatment, or where we are required to disclose information by the terms of our contract with your insurer or managed care company. ***You are also expressly authorizing your provider to pursue appeals and grievances with insurers or managed care companies when those appeals are necessary to obtain payment for one of your insurance claims or when your provider believes an appeal of denial of care by your insurer is appropriate or necessary.***

I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

I understand I may lose my right to treatment in this office if I break any part of this agreement.

Patient Information

Last Name: ____________________________ **First Name:** __________________________ **Middle Initial:** ___

Address: ______________________________ **City:** ____________________ **State:** ____________ **Zip:** ________

Date of Birth: ________________________________ **Gender:** (Circle one) M F

Marital Status: ☐ Single ☐ Married ☐ Other: __________ **Spouse Name:** ______________________________

School/ Employer____________________________________**Grade**______________

Race (Optional): ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ White

☐ Native Hawaiian or Other Pacific Islander ☐ Other: _________________

Ethnicity (Optional): ☐ Hispanic/Latino ☐ Not Hispanic/Latino

Home Phone: ___________________ **Work Phone:** __________________ **Cell Phone:** ____________________

Preferred Phone: (Circle one) Home Work Cell **May we leave a message:** (Circle one) Yes No

Preferred Method for Appointment Reminders: (Circle one) Phone Text Email

SSN: ___________________________ **Email Address:** _____________________________________

Emergency Contact: __________________________ **Phone:** _________________ **Relationship:** ____________

Responsible Party Information (If Not Patient)

Last Name: ____________________________ **First Name:** __________________________ **Middle Initial:** ___

Address: ______________________________ **City:** ____________________ **State:** ____________ **Zip:** ________

Date of Birth: _____________**SSN:** ____________________ **Relationship to Patient:** ______________________

Other Information

Pharmacy Name: ______________________ **City:** _____________ **State:** _____**Phone:** __________________

Primary Care Physician Name: _____________________________________ **Phone:** ________________________

Therapist: ____ **Phone:** _____________________________________

Insurance is considered a method of reimbursing the patient for fees paid to the provider, but usually does not pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is your responsibility to pay the remaining portion of the bill (unless otherwise restricted by law or agreement we might have with insurer).

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

I have read the "Policies and Procedures" on pages 1-2 and understand and accept the policies described. I agree to pay my insurance co-payment or deductible/co-insurance, and balance due prior to each session.

Patient or Responsible Party Printed Name: ____

Patient or Responsible Party Signature: ______________________ **Date:** _________________________

Witness: ____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

This **ACKNOWLEDGEMENT** THAT WE HAVE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR "NOTICE OF PRIVACY PRACTICES" is required by federal law. Thank you for your cooperation.

I, ____, acknowledge that I have received Lynn Hutchins Psychiatric
Patient Name Printed

Nurse Practitioner, PLLC the "Notice of Privacy Practices" and have had adequate opportunity to read and review the document.

CONSENT TO TREATMENT

I, ____, agree to receive treatment from Lynn Hutchins Psychiatric
Patient Name Printed

Nurse Practitioner, PLLC. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

PATIENT FEES/APPOINTMENT ATTENDANCE

PLEASE BE AWARE that when you make an appointment, that time is especially made for you. We really look forward to seeing you at your scheduled appointment. However, our goal is that all patients are seen in a timely manner; therefore, the following will be followed:

	Appointment Time Scheduled	
	Less than 30 minutes	**More than 30 minutes**
Cancellation/Reschedule (**with** -1 Business Day Notice)	No Charge	No Charge
Cancellation/Reschedule (**without** -1 Business Day Notice)	$75.00	$125.00
No Call/No Show	$75.00	$125.00
More Than 10 minutes late for appointment	Must Reschedule	

Insurance does not pay for Cancelled or No Show Appointments. The above fees will be an out of pocket expense for you as an individual. Our business days are Monday-Thursday. If you have an appointment scheduled for Monday, you must call before closing on Thursday to cancel or reschedule to avoid a charge.

I have read and understand this fee/attendance policy. I agree to pay according to the above guidelines.

Patient or Responsible Party Printed Name: ____

Patient or Responsible Party Signature: _____________________ **Date:** ________________________

Witness: ____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC

PLEASE READ CAREFULLY AND COMPLETE

PRIMARY INSURANCE INFORMATION

COPY OF CARD ON FILE ☐ or complete the following and provide a copy of the card as soon as possible.

INSURANCE COMPANY: ____

PATIENT INSURANCE ID NUMBER: ________________________________

INSURANCE ADDRESS: _______________________ CITY: __________________ STATE: _____ ZIP: _______

INSURANCE COMPANY PHONE: ______________________ GROUP NAME/NUMBER: ____________________

POLICY EFFECTIVE DATES: FROM _______________ TO _______________ EMPLOYER PLAN: ☐ YES ☐ NO

If insurance policy owner is someone other than the patient, please complete the following:

INSURED PARTY NAME: ____

INSURED PARTY ADDRESS: ____________________ CITY: __________________ STATE: ______ZIP: _______

INSURED PARTY PHONE: _____________________ INSURED PARTY DATE OF BIRTH: ____________________

INSURED PARTY SOCIAL SECURITY NUMBER: _______________________

Do you have any additional insurance coverage? (Circle one) Yes No

INSURANCE AUTHORIZATION

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU INITIAL EACH ITEM AND SIGN BELOW

_____ I authorize use of this form on all my insurance submissions.

_____ I authorized release of information to all my insurance carriers.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carriers.

_____ I authorize payment directly to my doctor or other health care provider, and hereby assign my right to reimbursement for services rendered to Lynn Hutchins Psychiatric, P.L.L.C.

_____ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Printed Name: ____

Patient or Responsible Party Signature: _____________________ **Date:** ________________________

Witness: ____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC Authorization Form

I authorize Lynn Hutchins Psychiatric to release health information to the following individuals. I understand that I have the right to rescind this authorization at any time by notifying Lynn Hutchins Psychiatric in writing.

Name: ______________________________ Relationship to Patient: ____________________________

- ☐ Appointment information __________ (initial)
- ☐ Protected Health Information __________ (initial)

Name: ______________________________ Relationship to Patient: ____________________________

- ☐ Appointment information __________ (initial)
- ☐ Protected Health Information __________ (initial)

I authorize the exchange of protected health information between Lynn Hutchins Psychiatric and the following:

Primary Care or Referring Physician:

Name: ____ Organization: ________________________

Address: ____

Office Phone: _________________________ Fax Number: ______________________________

Therapist:

Name: ____ Organization: ________________________

Address: ____

Office Phone: _________________________ Fax Number: ______________________________

Other:

Name: ____ Organization: ________________________

Address: ____

Office Phone: _________________________ Fax Number: ______________________________

AUTHORIZATION TO MAIL, CALL, TEXT, OR EMAIL

I understand the privacy risks of mail, phone calls, texts, and email. I authorize Lynn Hutchins Psychiatric to mail, call, text or email me with communications concerning my healthcare, including but not limited to things such as appointment reminders, referrals, laboratory results, or financial information regarding my services, including insurance claims. (This includes voicemail.) I understand that I have the right to rescind this authorization at any time by notifying Lynn Hutchins Psychiatric in writing.

Patient or Responsible Party Printed Name: ____

Patient or Responsible Party Signature: ______________________ **Date:** _________________________

Witness: ____

Lynn Hutchins Psychiatric Group

Health History

Name:_______________________________________ Date:______________

Indicate (Y) for yes and (N) for no for the following:
Have you recently had:

Fever ____	Weight Loss ____	Blurred Vision ____
Sore Throat ____	Sinus Problems ____	Chest Pain ____
Palpitations ____	Shortness of Breath ____	Wheezing ____
Asthma ____	Diarrhea ____	Abdominal Pain ____
Urinary Problems ____	Sexually Transmitted Disease ____	Weakness ____
Diabetes ____	Bleeding ____	Bruising ____
Muscle Pain ____	Heat-Cold Intolerance ____	Seizures ____
Dizziness ____	Depression ____	Anxiety ____
Rash ____		

What is the reason/medical problem for your visit? _________________________

____

____

How long have you had the problem? _____________________________________

Does anything cause the problem or make it worse? _________________________

____

What medication do you take now? ______________________________________

____

____

Do you have any pain? ___________________________Rate the pain 1-10 _____

____

Signature of Patient

Lynn Hutchins Psychiatric Group

Controlled Substance General Patient Agreement

Some of the medications commonly prescribed in this office are controlled substances and can be addictive, such as benzodiazepines (Klonopin, Xanax, Valium, Ativan) and stimulants (Adderall, Ritalin, etc). It is important that these medications be used responsibly.

I, ___________________________________, understand and voluntarily agree that (initial each statement after reviewing):

______I will keep (and be on time) for all my scheduled appointments.

______I am responsible for my medicines. I will keep the medicine safe, secure and out of the reach of children. If the medicine or prescription is lost, stolen or is used up sooner than prescribed, I understand that it will not be replaced until it is due for refill, and may not be replaced at all.

______I will take my medication as instructed and not change the way I take it without first talking to my prescriber at this practice.

______I understand that altering a written prescription in any way will result in immediate termination from this practice. Additionally, it is illegal to alter a prescription in any manner and could result in criminal charges.

______I will not call at night or on the weekends to ask for refills. I understand that refill requests will be made during scheduled office hours only. I further understand that **48 business hours'** notice is required for all stimulant prescription requests (Adderall, Ritalin, Vyvanse, etc.) and **24 business hours'** are required for all other refill requests.

______I will only use one pharmacy to get my controlled medications filled: ____________________.

______I agree to give a blood, saliva, and/or urine sample, if asked, to test for drug use.

______I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

______I will not sell this medicine or share it with others. I understand that if I do, my treatment will be stopped.

______I will tell my prescriber at this practice all other medicines that I take, and let them know immediately if I have a prescription for a new controlled substance from another provider.

______I will not get any other medicines that can be addictive such as benzodiazepines (klonopin, Xanax, valium, etc.), stimulants (ritalin, amphetamine, vyvanse, etc.) or opioid pain medicines without telling my prescriber at this practice **before I fill that prescription**. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

______I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient Name: ____ Date of Birth: ___________________

Signature: ____

Date: ____

Witness: ____

Revised 06/2019