Colleen A. Blanchfield, M.D.
11490 Commerce Park Drive Suite 420 Reston VA 20191
Tel 703-481-9111 Fax 703-707-8657 Email FCNWC@CBlanchfieldmd.com

PATIENT REGISTRATION

Patient Information:

Patient's Legal Name_____ Sex_____

Patient's Social Security #_____ Patient's Date of Birth_____

Patient's Home Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____ Email_____

Employer's Name_____ Position_____

Work Address_____ Work Phone #_____

Referring Doctor_____ Doctor's Phone #_____

Guarantor Information: person financially responsible for the patient's account.

Guarantors must sign the Authorization and Financial Agreement on page 7.

Guarantor's Legal Name_____

Guarantor's Social Security #_____ Guarantor's Date of Birth_____

Guarantor's Address_____

City_____ State_____ Zip Code_____

Guarantor's Home Phone #_____ Guarantor's Cell Phone #_____

Guarantor's Employer's Name_____ Work Phone #_____

Note: In separation and/or divorces cases, in which your spouse or your spouse's family member is the guarantor, if we have not been notified of such occurrence in writing at our office, then both the patient and the guarantor are liable for payment of services until we are notified. When we are notified of such separation/ divorce, we will then first bill the patient for full payment of any amounts due for prior services. Such guarantor will not be responsible for services rendered after the notification date, and they will not be billed for such services.

Health Insurance Information

Be sure to notify us should this information change.

--Please provide insurance cards for us to copy.

Primary Insurance Company:_____ Phone #_____

Subscriber's Name_____ Date of Birth_____

Subscriber's Social Security #_____ Relationship to Patient_____

Policy ID #_____ Group #_____

Secondary Insurance Company:_____ Phone #_____

Subscriber's Name_____ Date of Birth_____

Subscriber's Social Security #_____ Relationship to Patient_____

Policy ID #_____ Group #_____

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Emergency Contact Information

Name_____ Relationship to Patient_____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____ Email #_____

Work Phone #_____ Work Address_____

Confidentiality

To provide you with the appropriate care, we may need to consult with others. The confidentiality of the work that we do together with you is upheld; however there are exceptions to the rule:

- If we suspect that child abuse has occurred, the law requires that it be reported to the authorities.
- If we believe that you are in imminent danger to yourself or another person, we may notify others to attempt to prevent that occurrence.
- If it becomes necessary to contact an attorney or a collection agency to collect amounts you owe this practice, then your name, information about how to reach you, the amount owed, the reasons for the amount owed becomes available, and if court action is necessary, it may become public record.
- In legal proceedings, the patient/doctor communications are privileged with the following exceptions:
  - If your mental status is an issue for the court.
  - If the doctor is deposed, and your attorney does not take the necessary legal action to stop the deposition.
  - If the judge feels the communications are necessary to the proper administration of justice
- If you are a participant in an HMO or a Managed Mental Health Care Company, they may require completion of outpatient treatment reports, in which case summaries will be provided upon request.
- If you are to be admitted for hospitalization or in-patient treatment, your insurance company may require that we share our findings in order to get authorization for such services.
- If we have not been paid for our services, we contract your insurance companies to determine if they have paid you for the services we rendered. By signing this document, you are releasing us to discuss the services with the insurance companies, and you are releasing the insurance companies to discuss their claim payments (to you or us) with us.

Acceptance:

I have reviewed this document and understand the policies described herein. My signature below evidences my acceptance of such policies.

Patient Name: _____
(print name)

_____ _____
(signature) **(date)**

Legal Guardian (if patient is under 18 years old or assigned a legal guardian):

_____
(print name)

_____ _____
(signature) **(date)**

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Patient Record of Disclosures

Our privacy practice gives you the right to request confidential communication on your protected health information.

I wish to be contacted in the following manner (check all that apply):

Please note that our AutoRemind system uses an email reminder a week prior to your appointment and one to your cell phone three days before your appointment.

☐ Home Tel. Number_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave any messages at this number

☐ Cell Tel. Number_____
- ☐ O.K. to leave message with detailed information
- ☐ O.K. to text appointment reminder messages
- ☐ Leave message with call-back number only
- ☐ Do not leave any messages at this number

☐ Work Tel. Number_____
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Do not leave any messages at this number

☐ Written Communication _____
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work address

☐ Email Address _____
- ☐ O.K. to email message with detailed information
- ☐ O.K. to email appointment reminder messages
- ☐ Email message with call-back number only
- ☐ Do not email any messages at this number

Patient Name: _____
(print name)

_____ _____
(signature) **(date)**

Legal Guardian (if patient is under 18 years old or assigned a legal guardian):

_____
(print name)

_____ _____
(signature) **(date)**

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Summary of Authorization and Financial Agreement

This summary is provided to assist you in understanding the Authorization and Financial Agreement.

The Authorization and Financial Agreement contains a detailed description of our office's financial and medication policies. Please refer to that document for further information.

- This practice is fee-for-service: payment in full is due at the time of service. Failure to pay at the time of service will result in an additional charge of $25. That is an additional $25 for each date of service not paid at the time of service.
- This practice is out-of-network with all insurance companies including Tricare, does not participate with Medicaid, and has opted out of Medicare as of March 3, 2014.
- Before leaving the office, make sure that you have **all** of your medication prescriptions. As, you are prescribed enough medication to last until your next appointment
- If a medication refill is requested at a time other than your appointment there is a charge of $100 to be paid in advance. Medication will be refilled at Dr. Colleen Blanchfield's discretion.
- Medication prescriptions **will not** be mailed to your home.
- You **will not** be given medication if you have not been seen for 3 months.
- The practice **does not** respond to pharmacy-generated medicine refill requests. If you need a refill contact the office. It usually takes **1-2 business days** for medications to be approved and called into the pharmacy.
- The practice **does** respond to medication prior authorization requests from the pharmacy.
- If you do not attend an appointment for more than six months you will be considered a new patient and seen at Dr. Colleen Blanchfield's discretion.
- Arriving 15 minutes or more late for a medication appointment will result in a charge the full cost of the appointment for **all** services.
- Cancellation of an appointment less than **48 hours** before the appointment date and time, failure to show up for an appointment, or arriving 15 minutes or more late for an appointment time for any reason will result in a charge of the full price of the appointment scheduled for all services.
- All balances must be paid prior to scheduling an appointment. This includes billed charges such as those for no shows, late cancellations, prior authorizations, completion of forms and letter, testing, etc. and well as any appointment charges not paid at the time of service and the additional associated late fee of $25.

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Authorization and Financial Agreement

Colleen Ann Blanchfield, M.D. ("Full Circle Neuropsychiatric Wellness Center") is a fee-for-service medical practice. As such, I understand that I will be expected to pay for charges at the time services are rendered by cash, check, or credit card.

I am aware that Full Circle Neuropsychiatric Wellness Center does not participate with any insurance companies and is therefore an out of network provider. I understand that it is my responsibility to contact my insurance company to determine if, and how much, of services provided by Full Circle Neuropsychiatric Wellness Center my insurance company will cover. I am aware that as a fee-for-service practice I will be expected to pay for charges at the time of service. I understand that my insurance company's coverage, payments, disputes, and errors will have no bearing on my responsibility to pay for charges at the time of service.

I understand that at the time of service, Full Circle Neuropsychiatric Wellness Center will provide me with an "Encounter" form which contains information that I may use to file a claim with my insurance carrier. This form contains Current Procedural Terminology (CPT) codes, diagnostic codes, and provides insurance carriers with <u>most</u> of the necessary information with which to determine if such service is covered. I understand that it is my responsibility to contact my insurance carrier for specific forms and instructions pertaining to their claims submission process. I understand that it my responsibility to submit insurance forms, and corrected forms, to my insurance company within the limits of timely filing. I am aware that failure to do so will most likely result in non-payment by my insurance company and this does not affect my responsibility to pay Full Circle Neuropsychiatric Wellness Center for charges at the time of service. I understand that any request for additional copies of Encounter forms beyond those given at my appointment can take up to two weeks to complete with an additional charge.

I am aware that Full Circle Neuropsychiatric Wellness Center has opted out of Medicare. I understand that I am solely responsible to pay for all services in full at the time of service and neither I nor Full Circle Neuropsychiatric Wellness Center will receive reimbursement from Medicare. If I have Medicare, primary or secondary, I am required to sign a private Medicare opt out contract with Full Circle Neuropsychiatric Wellness Center if I wish to continue treatment unless I require emergency care services or urgent care services.

I understand that I am responsible to contact Full Circle Neuropsychiatric Wellness Center concerning any change in my contact or insurance information.

<u>Outstanding Balances:</u>

If I fail to pay for the appointment charge on the day of service, I understand there will be an additional charge of $25. I understand that this additional charge is not reimbursed by insurance. If I do not understand the statement that I receive for an outstanding balance, it is my responsibility to contact Full Circle Neuropsychiatric Wellness Center at 703-481-9111 with any questions. Full Circle Neuropsychiatric Wellness Center has the right to refuse service if the balance is not paid prior to this service.

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Request for Medicine Refills:

I understand that I will be prescribed enough medication to last until my next appointment. If I request medicine refills at times other than my appointment there is a charge of $100. It is my responsibility to schedule appointments accordingly and make sure I am given all medication before leaving the office. I understand that Full Circle Neuropsychiatric Wellness Center does not respond to pharmacy-generated medicine refill requests and I must contact the office directly to request a refill of my medication. If my request is approved, I understand that I may only request a medicine refill once before attending my next appointment. Medication prescriptions will not be mailed. I will not be given medication if I have not been seen for 3 months. I understand that if I do not attend an appointment for a period of time in excess of six months that I will be scheduled, and complete a new intake, at Dr. Colleen Blanchfield's discretion.

Completion of Forms:

If I request Full Circle Neuropsychiatric Wellness Center to complete a form and/or write a letter, I understand that there is a charge of $50-$225 for the time needed to complete the form/letter that is due prior to its completion. This includes but is not limited to forms/letters pertaining to insurance, employment, school, disability, retirement, legal action, and prior authorization for medications. I understand that if I request Full Circle Neuropsychiatric Wellness Center to complete multiple forms/letters for the same purpose there is a charge for each form/letter completed. This includes but is not limited to condition updates and return dates for disability, employment, school, and prior authorization renewals. I understand that this charge is not reimbursed by insurance. I am aware that I should bring all forms and pertinent information with me at the time of my appointment. I understand that requests can take up to four weeks to complete.

Medical Records Request:

I understand that a request for copies of my medical records must be in writing, dated and signed, and include a reasonable description of the records sought. I understand to have my medical records sent to an individual including myself that I must complete a release of information to include the contact information of the individual for verification purposes. I am aware that I will be charged a reasonable fee consisting of $0.50 per page for the first 50 pages, $0.25 for each additional page, a flat fee of $10.00, plus any postage costs if I request that the copies be mailed. I am aware the fee for this service is due in advance of my records being released. I understand that medical records requests can take up to four weeks to complete.

Prior Authorizations:

I understand that my insurance company may require prior authorization to cover my medication. Completion of the prior authorization process may take up to two weeks and there is an additional charge of $25 that is not reimbursed by insurance. I understand that completion of the prior authorization process does not guarantee approval of coverage by my insurance company and I am still responsible for payment of the $25 charge if the prior authorization is denied by my insurance company.

Cancellation Policy:

I understand that I am solely responsible for scheduling and attending my appointments. I understand that all appointments that I schedule are final and that in no instance an appointment will be held for me pending my confirmation. I understand that if I do not cancel an appointment at least 48 hours before the appointment date and time, if I fail to show up for an appointment, or if I arrive 15 or more minutes late for my scheduled appointment time for any reason there will be a charge of the full price of the appointment(s) scheduled for all services. I understand that I must pay this charge prior to my next scheduled appointment. I am aware that if I

fail to pay this charge prior to my next scheduled appointment Full Circle Neuropsychiatric Wellness Center may deny me service until the balance is paid.

This document explains my financial responsibilities as a patient. I recognize that I have the right to ask for assistance in understanding this document prior to signing it and that I will be given a copy of this agreement upon request.

If I fail to pay my outstanding balance and collection costs are incurred, including but not limited to legal fees, court costs, summons costs, collection agency cost, etc., then I am responsible for such collection costs. Further, I understand that the laws of Fairfax County and the Commonwealth of Virginia will govern this agreement.

This agreement constitute all the terms and conditions agreed upon between myself and Colleen Ann Blanchfield, M.D. ("Full Circle Neuropsychiatric Wellness Center") and supersede any prior agreements in relation to the subject matter of this agreement, whether written or oral. Any additional or different terms or conditions in relation to the subject matter of this agreement in any written or oral communication from myself to Colleen Ann Blanchfield, M.D. are void. I represent that I have read this document containing the terms and conditions of being a patient of Colleen Ann Blanchfield, M.D. and agree to abide by, and be obligated by, such terms and conditions. I have not accepted this agreement in reliance on any oral or written representations made by Colleen Ann Blanchfield, M.D. that are not contained in this agreement.

Patient Name: _____
(print name)

_____ _____
(signature) **(date)**

Guarantor (or Legal Guardian if patient is under 18 years old or assigned a legal guardian):

_____
(print name)

_____ _____
(signature) **(date)**

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ePrescribe Registration Form

Date: _____

Patient Information:

Patient's Full Legal Name _____
(first name) (full middle name) (last name)

Patient's Social Security #_____ Patient's Date of Birth_____

Patient's Home Address_____

City_____ State_____ Zip Code_____

Home Phone #_____ Cell Phone #_____

Allergies & Reaction that occured: ☐ None Known

_____

_____

_____

_____

_____

_____

Mail Away Pharmacy Information

☐ The mail away pharmacy already on file with the office is current and correct.

Pharmacy Name:_____ Phone #_____

Pharmacy Address_____

City_____ State_____ Zip Code_____

Local Pharmacy Information

☐ The local pharmacy already on file with the office is current and correct.

Pharmacy Name:_____ Phone #_____

Pharmacy Address_____

City_____ State_____ Zip Code_____

* Pharmacies listed above that do not contain the complete address and phone number of the pharmacy cannot be verified or entered into our system.

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Acknowledgement of Receipt of Privacy Practices

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read (or had the opportunity to read if I so choose) and understood the Notice.

Patient Name: _____
(print name)

_____ _____
(signature) **(date)**

Legal Guardian (if patient is under 18 years old or assigned a legal guardian):

_____
(print name)

_____ _____
(signature) **(date)**