Centerway BEHAVIORAL HEALTH

Patient Information

First Name	Last Name	Middle Initial	Preferred Name
Address	City	State	Zip
Date of Birth	Social Security Number	Driver's License Number	
Home Phone Number	Mobile Phone Number	Email	
Name of Employer	City of Employment	Work Phone Number (optional)	

Do you think of yourself as (Check one):
- ☐ Heterosexual
- ☐ Lesbian
- ☐ Gay
- ☐ Bisexual
- ☐ Other: _____
- ☐ Choose not to disclose

What is your current gender identity? (Check one):
- ☐ Female
- ☐ Male
- ☐ Non-Binary
- ☐ Gender-Fluid
- ☐ Other: _____
- ☐ Choose not to disclose

What sex were you assigned at birth? (Check one):
- ☐ Male
- ☐ Female

Preferred Pronoun(s): _____

Will you be in the state of SC during your appointment? ☐ Yes ☐ No

In the past 4 years, have you lived outside the state of SC? ☐ Yes ☐ No If so, where? _____

Name of Preferred Pharmacy	Street Address	City	State	Zip Code	Phone Number

Are you fully vaccinated against COVID-19?
☐ Yes ☐ No ☐ Partial (Date of second vaccine: _____/_____/_____)

Do you personally know or are related to a current patient of Centerway? ☐ Yes ☐ No
If yes, please identify your relationship to this individual:

How were you referred to us?
- ☐ Internet Search
- ☐ Counselor
- ☐ Primary Care Provider
- ☐ Other (please specify):

Emergency Contact Information

Name			
Address	City	State	Zip
Home Phone Number	Mobile Phone Number	Relation to Patient	

If have insurance card to photocopy, please omit this section

Insurance Information Part 1

Name of Primary Insurance Company	Insurance Company Address	City	State	Zip
Policy Number / ID or Member Number	Group Number	Insurance Company Phone Number		

If have insurance card to photocopy, please omit this section

Insurance Information Part 2

Name of Policy Holder (the person in whose name the insurance policy is held)	Date of Birth	Relationship to Patient ☐ Spouse ☐ Child ☐ Other:

Address of Policy Holder	City	State	Zip Code	SSN of Policy Holder

Note: If you have a secondary insurance company, please write all the information on the back of this page.

I hereby authorize Centerway Behavioral Health to furnish information to insurance carriers concerning my illness and treatments; and I hereby assign Centerway Behavioral Health all payments for medical / mental health services rendered to myself or dependents. I understand that Centerway Behavioral Health charges regardless of coverage.

_____ _____
Signature Date

Please do not mark in the area below unless asked to (we use the space for referral consent information)

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Patient History and Information

Current Medications
Please list all medications (name, dose, and time of day taken).

Prior Medications
Please list all prior psychiatric medications that you are not currently taking.

Allergies
Allergies and type of reaction.

□ No known drug allergies

Past Psychiatric History
Please list all prior psychiatric diagnoses, and mental health hospitalizations (if any).

Past Medical History
Please list all medical diagnoses and prior surgeries.

Review of Systems
Please circle any that apply:

	Detail
• Cardiovascular: chest pain, dizziness, palpitations, high blood pressure, murmur, elevated cholesterol	
• Constitutional: Unexplained weight loss, fatigue, night sweets, appetite changes,	
• Endocrine: diabetes, thyroid problems, excessive thirst	
• Eyes: vision changes, double vision, blind spots in vision	
• ENT: sinus pain, ear pain, frequent nose bleeds	
• Gastrointestinal: nausea, vomiting, change in bowel habits	
• Genitourinary: pain with urination, excessive urination,	
stiffness, joint swelling, decreased range of motion	
• Musculoskeletal: muscle pain, abnormal movements due to medication	
• Neurologic: seizures, stroke, tremors, head injury, loss of consciousness	
• Respiratory: cough, sputum, wheeze, shortness of breath	
• Integumentary / Skin: rash, itchiness, skin discoloration, wounds, nodules	
• Psychiatric: depression, anxiety, prior emotional trauma, elevated energy, recklessness, difficulty concentration	

[ ] **Provider reviewed all positive notations from the review of systems listed above, unmarked selections are negative.**

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Credit Card Authorization Form

Late cancellations and no-shows hurt our ability to provide excellent care to our patients. When it occurs, it harms two people: the patient who missed timely care, and the patient next in line who needed an appointment but lacked an opportunity to schedule and is left without care.

By signing this form, you give Centerway Behavioral Health permission to charge your card for any **late cancellations or appointment no-shows (please see Authorization for Treatment, Practice Policies, and Payment Form for details).** Your credit card will be charged 7-10 days after the occurrence.

We understand that unforeseen events may occur, and we will consider each missed appointment on a case-by-case basis (Examples of unforeseen events that merit a waiver include medical illness with any form of documentation, hospitalizations, and extreme flooding. Examples where we will not waive include business travel, and general statements that someone didn't feel well).

By signing this form, you also give Centerway Behavioral Health permission to charge your card for any **past due amount**. That said, we know some insurances take longer to process than others, and we will give adequate time before charging an unpaid amount, depending on the situation, and insurer.

- We will contact you prior to charging your card for any amount over $50.
- This card that you put on file needs to be a working card at all times (i.e., not a debit/HSA/FSA card which may not contain the funds available to charge).

Please complete the following:

I *(patient),*_____, authorize Centerway Behavioral Health to charge the credit card /debit card below, for any late cancellations, appointment no-shows, or past due amounts described above.

Credit Card Type:

☐ Visa

☐ American Express

☐ Mastercard

☐ Discover

Credit Card #: _____

CVV Code: _____ Expiration Date: _____

Billing Address: _____

Phone Number: _____ Email: _____

Notice: If the credit card you are choosing to authorize is not your own (another cardholder's name), please let our office know and we will have you complete a "Third Party" authorization form instead of this one.

I hereby authorize Centerway Behavioral Health to charge the credit card indicated in this authorization form according to the terms outlined above. Charges will post as "Amount Due". I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in this form.

_____ _____

Signature Date

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Permission to Verbally Discuss Protected Health Information with Family/Friends

---Completion of this form is optional---

Patient Name _____ **Date of Birth** _____

Home Phone _____ **Mobile Phone** _____

I give permission for Centerway Behavioral Health to VERBALLY share the information I have check with the family, friends, or others that I have identified below as being involved in my health care, care coordination or payment of healthcare (check all boxes that apply). This form does not authorize releasing copies of my records.

- ☐ Scheduling / Appointment Information
- ☐ Medical and Behavioral Health information, including my symptoms, diagnosis, medications, and treatment plan
  - ☐ Substance use disorder (if any)
- ☐ Lab / test results
  - ☐ HIV results (if any)
- ☐ Billing and payment information
- ☐ Other (describe): _____

Centerway Behavioral Health has my permission to discuss the information above with the following family, friends, other people. This information is directly relevant to their involvement in my health care (or payment for that care).

Individual 1	Name:_____ Relationship:_____ Address:_____ City:_____State:_____ Zip:_____ Phone:_____
Individual 2	Name:_____ Relationship:_____ Address:_____ City:_____ State:_____ Zip:_____ Phone:_____

I understand that in certain situations the Centerway Behavioral Health may speak to other individuals who are involved in my care or payment of that care, if permitted by law, that may not be identified on this form. I understand that I have the right to revoke my permission at any time except where Centerway Behavioral Health has already made disclosures in reliance upon this request. I understand this permission remains in effect until the time I revoke it in writing.

Signature of Patient / Authorized Representative: _____ Date: _____

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Authorization for Treatment, Practice Policies, and Payment

As the patient or patient's legal representative, I hereby consent to necessary examination, treatment and procedures prescribed at Centerway Psychiatry and Behavioral Health, by Erik Cantrell MD, and affiliate practitioners, assistants, or designees.

All fees, co-pays and co-insurance for office visits and other charges, are due and payable at the time of the appointment. It is your responsibility to pay your account. Our office will provide documentation for all visits to be used by you for filing with your insurance company if we do not file with you plan. It is your responsibility to inform us of any changes in your insurance plans and to obtain initial authorization if required by your plan. For delinquent accounts, the balance may be turned over to a collection agency. If so, you will be responsible for their fee.

Cancellation Policy and No-Show Fees.
You must call our office directly for any cancellation/reschedule requests. You will be charged the fee written in the billing policy if you do not cancel or reschedule your upcoming appointment before 3pm the previous business day prior to your appointment.

As a courtesy we do try to remind our patients of upcoming visits, however, in the event that we are unable to give you a reminder phone call, you will still be responsible for keeping up with and keeping your appointments.

As normal doctors' offices sometimes run behind, so do we. It is important that you carve out the appropriate amount of time in your day for your visit with us (just like a normal doctor's office visit), even if it is a virtual visit. Sometimes we experience crisis within clinic, and it puts us a little behind during the day, but we still want to see you! We ask and thank you for your patience when this occurs.

Examinations, consultations, reports, and testimony performed for legal purposes are billed at a separate rate. Changes in medication dosages will be made at an appointment and not via telephone in order to provide the best care for you. If you have a medical emergency when the office is closed call 911, visit a medical emergency room or a local psychiatric hospital for evaluation.

The undersigned, hereby authorize the medical offices of Centerway Behavioral Health, including but not limited to professional staff and agents, to release all medical information about me, including but not limited to my medical records, that is necessary to process any claims for insurance or reimbursement. I thereby also authorize and assign payment of any and all medical benefits to Centerway Behavioral Health for services rendered. This authorization shall remain in effect until I specifically notify Centerway Behavioral Health in writing that you are revoking this authorization.

I have read the information listed above and have been given the opportunity to ask questions. I understand, agree, andauthorize.

_____ _____

Patient Signature Date

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Telepsychiatry Consent for Treatment

To better serve the needs of people in the community, health care services are now available by interactive video communications and/or by the electronic transmission of information. Telepsychiatry is the delivery of psychiatric services using interactive audio and visual electronic systems where the psychiatrist and the patient are not in the same physical location. These systems used in telepsychiatry incorporate network and software security protocols to protect the confidentiality of patient information and audio and visual data. Since this may be different than the type of consultation with which you are familiar, **it is important that you understand and agree to the following:**

My Rights

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry.
2. I understand that the telepsychiatry platform used by Centerway Behavioral Health, LLC is encrypted to prevent the unauthorized access to my private medical information.
3. I understand that I may withdrawal my consent to the use of telepsychiatry during the course of my care, but that doing so will result in needing to attend in-office visits if I would like to continue my treatment.
4. I understand that attending in-office visits with Centerway Behavioral Health, LLC. require me to be fully vaccinated (two injections) for COVID-19.
5. I voluntarily consent to health care services provided by my provider, which may include diagnostic tests, drugs, examinations,and medical or surgical treatments considered necessary to treat my health problem.
6. I understand that the Centerway Behavioral Health, LLC. provider has the right to withhold or withdraw his consent for the use of telepsychiatry during the course of my care at any time.
7. I understand that all rules and regulations which apply to the practice of medicine in the state of South Carolina also apply to telepsychiatry.

My Responsibilities

1. I will not record any telepsychiatry sessions without written consent from the Centerway Behavioral Health, LLC. provider. I understand that all Centerway Behavioral Health, LLC. providers will not record any of our telepsychiatry sessions without my written consent.
2. I will inform the Centerway Behavioral Health, LLC. provider if any other person can hear or see any part of our session before the session begins.
3. Any Centerway Behavioral Health, LLC. provider will inform me if any other person can hear or see any part of our session before the session begins.
4. I understand that I, not the Centerway Behavioral Health, LLC. provider, am responsible for the configuration of any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
5. I understand that telepsychiatry services can only be provided to patients, including myself, who are physically in the state of South Carolina at the time of service.
6. I understand that there may be circumstances in which I will be required to come into the office for appointments but will be made aware of this information beforehand.
7. I accept financial responsibility for my appointments should my insurance provider not cover medical expenses related to telepsychiatry services.

Patient Consent to The Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, and all of my questions have been answered tomy satisfaction. I hereby give my informed consent for the use of telepsychiatry in my care and authorize Centerway Behavioral Health, LLC. to use telemedicine in the course of my diagnosis and treatment.

Signature of Patient/Representative _____ Date _____

Patient Printed Name _____ Date of Birth _____

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Billing Policy

Financial Policy:

- Co-insurance, copay and/or deductible payment is due at time of service by cash, money order, Visa, MasterCard, Discover, or American Express. Depending on the level of service provided there may be an additional fee that is patient responsibility to pay within 30 days of receipt of your statement.
- Patients are responsible for their co-payments and/or deductibles at the time services are rendered for patients on Preferred Provider Plans (PPO's) or Health Maintenance Organizations (HMO's).
- Any balance on an account that is greater than 30 days old is considered past due. It must be paid prior to your next visit.

Insurance:

- Your insurance policy is a contract between you and your insurance company. While our billing professionals will do all they can to help our patients in communicating and negotiating with your insurance plan, the ultimate responsibility for questions regarding coverage, benefits, or payment for services provided is yours.
- In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to Coordination of Benefits information will become your responsibility after thirty (30) days.
- Centerway Behavioral Health and its employees / affiliates do not guarantee that payment will be authorized for medical services; therefore, this office is not responsible for any adverse payment decisions or misuse of information.
- Notification of any change in your insurance status (i.e., new company, deductible, co-pay amounts) must be providedto the office forty-eight (48) hours in advance of next visit, or payment in full will be required.

Miscellaneous Charges:

- Fees for medical records are $35.00 for the first 20 pages, and $0.10 for each page thereafter and may take up to 7 business days to obtain. Report preparation fees are based on the time involved.
- Any returned checks are subject to a $35 service fee. Any returned check must be resolved before any future appointments can be arranged.
- Centerway Behavioral Health may contract with a bill collection agency, to collect delinquent accounts. Once an account is placed with a collection agency, the patient must deal directly with that agency for payment of the account. In the event of account placement with a collection agency, the applicable collection fees will be added to that account.Currently, these additional fees are likely to be 25% of the total balance owed.
- If you need to reschedule an appointment, please call our office directly in a timely manner. The fee for late cancelations, or not attending your appointment (no-show) is $50. The amount of notice we need to reschedule an appointment without it being considered a late cancelation is outlined in the form Authorization for Treatment, Practice Policies, and Payment. You will only be charged one fee for an issue with an appointment,(i.e., it may be considered a late cancelation or a no show, we will not bill you for both amounts). This fee is not billed to your insurance company. Please help us serve you better by keeping your scheduled appointments or canceling in advance.

I have read the information listed above and have been given the opportunity to ask questions. I understand and agree.

_____ _____

Patient Signature Date

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Dismissal Policy

It is the policy of this practice to maintain a cooperative and trusting physician-patient relationship with its patients. When such a physician-patient relationship has not been formed or a physician-patient relationship is no longer proceeding in a mutually productive manner, it is the policy of this practice to terminate the physician-patient relationship within the bounds of applicable state and federal laws, rules, and regulations; the American Medical Association guidelines, and this policy so that the patient can develop the type of trusting relationship with another physician that is essential to successful continued care and treatment.

The types of circumstances that can result dismissal include, but are not limited to, the following:

- Noncompliance with treatments recommended by the practice, physician, or other healthcare provider
- Failure to pay, consistent with our payment policy
- Chronically failing to keep appointments
- Threatening or abusive behavior directed at office staff, physicians, other healthcare provider, or other patients.
- The patient is deceptive or lies
- Misuse / abuse of prescriptions and medications
- The provider determines he/she cannot provide continued, effective care
- Threat of legal action against Centerway providers, or employees.

If a patient is dismissed from our clinic, they (or their legal representative) will be notified by certified mail of this action, and the notice will include the reason for dismissal, and referral sources to aid in finding another provider. In addition, our clinic will continue to provide emergency services during our regular office hours for 30 additional days, and we will forward any medical record if requested (as per our policy regarding the sharing of medical information).

I have read and agree to abide by the policy outlined above.

_____ _____

Patient Signature Date

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HIPAA Notice of Privacy Policies

Effective date 7/19/19

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully. If you have any questions about this notice please contact Erik Cantrell, MD at 843.974.5622

We are required by law to:

- Maintain the privacy of protected health information
- Give you this notice of our legal duties and privacy practices regarding your health information
- Follow the terms of the notice current in effect

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Erik Cantrell, MD.

Treatment: We may use and disclose your health information for treatment and to provide you with the treatment related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside of our office, who are involved in your medical care and need the information to provide you with medical care.

Payment: We may use and disclose your health information so that we, or others, may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, with your consent, we may give information to your health plan if they will help pay for your treatment,

Health care operations: We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Appointment reminders, treatment alternatives, and health-related benefits and services: We may use and disclose your health and contact information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use. For example, we will assume that we may leave a message at a phone number or email address you have given us to respond to contact from you, to remind you of an appointment or to change one, or to contact you for an urgent matter unless you specifically withdraw that permission in writing.

Individuals involved in your care: In an emergency, we may share your health information with persons involved in your care (such as your family or a close friend) or disclose your location or condition information to an entity assisting in emergency treatment or disaster relief. When contacting you by phone, email or post we may identify ourselves. This may include telling the person answering the phone who is calling.

As required by law: We will disclose your health information when required to do so by international, federal, state or local law. In South Carolina a judge may mandate release of your medical information.

To avert a serious threat to health or safety: we may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosers will be made only to someone who can prevent the threat.

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Business associates: We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services, dictation services, or debt collection on our behalf. All our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Workers' compensation: We many release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

Military and veterans: If you a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military, we may release your health information to the foreign military command authority.

Public health risks: We may disclose your health information for public health activities to prevent or control disease, injury, or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunction or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Health oversight activities: We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and disputes: We may release your health information requested by law enforcement official if I) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about a death that may be the result of criminal conduct; 4) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 5) the information is relevant to criminal conduct on our premises; 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime, and 7) South Carolina law

Coroners, Medical Examiners and Funeral Directors: We may release your health information to a coroner, medical examiner, or funeral director to identify a diseased person or cause of death, or other similar circumstance.

National security and intelligence activities: We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Inmates or individuals in custody: If you are an inmate of a correctional institution or in custody, we may disclose your information 1) for the institution to provide you with health care; 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

Right to an accounting of disclosures: You have a right to an accounting of certain disclosures by written request to Erik Cantrell MD, or Centerway Behavioral Health, LLC.

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Right to request restrictions: You have the right to request restriction or limitation on your health information used for treatment, payment, or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care (such as a spouse) by written request to Centerway Behavioral Health, LLC or Erik Cantrell MD, we are not required to agree with your request, but we will try to comply.

Right to request confidential communication: You have the right to request that we communicate with you about medical matters in a certain or at a certain location. You can ask, for example, that we contact you only by mail or at work, your written request must specify how or where wish to be contacted and be addressed to Centerway Behavioral Health, LLC. or Erik Cantrell MD. We will accommodate reasonable requests.

CHANGES TO THIS

The current notice will be always posted and available. You have a right to request a paper copy of the notice. We may change this notice and make it effective for medical information we already have about you as well as new information current notice at any visit or by written request to Centerway Behavioral Health or Erik Cantrell MD.

I have read the information listed in this policy, have been given the opportunity to ask questions, and understand the information.

_____ _____

Patient Signature Date