Rupinder Kaur M.D.

Kaur Psychiatric Associates, PA
3300 Battleground Ave #100 Greensboro, NC 27410
336.645.9555 phone 866-324-5202 fax
Diplomate American Board of Psychiatry & Neurology

Date: _____ Referred By:_____

Name: _____
(LAST) (FIRST) (M.I)

Address:_____
(ZIP CODE)

Sex:_____ Birth Date:____/____/____ Marital Status:_____ Social Security:_____ ___ ____

Primary Number: ( )_____-_____ Email Address: _____@_____

May we leave you a <u>detailed</u> message? : ☐ yes ☐ no

Are you a student? _____ If so, Full-Time or Part-Time?_____

Emergency Contact:_____ Phone #:_____

Relationship of Contact:_____

Is this person authorized to access your medical information? _____YES _____ NO

Please check what they may access _____Billing _____Appointments _____Meds

<u>Primary Insurance</u>

PLEASE INCLUDE A COPY OF THE <u>FRONT AND BACK</u> OF YOUR INSURANCE CARD

Insurance Co:_____ Policy Holder's Name:_____

Policy Holder's DOB:_____ Employer:_____

I DO/ DO NOT (circle one) authorize Kaur Psychiatric Associates, P.A. to contact my primary care physician.

Name of Physician:_____

Patient's Signature:_____ Date: _____

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FINANCIAL INFORMATION

Payment is required at time of service. We submit insurance claims for companies with whom we have a contract and are your PRIMARY insurance company. Our office will not submit a claim for a secondary insurance company. **ALL DEDUCTIBLES, COPAYS AND COINSURANCE MUST BE PAID AT TIME OF CHECK IN.** If nonpayment of this account results in placement with a collection agency, a $75 processing fee will be assessed.

Most insurance companies require that YOU call them for pre-certification of your first visit with us. If you do not obtain this certification, your insurance may not pay for your evaluations and you will be responsible for the entire bill. You need to be aware of the provisions of your insurance policy, as it is a contract between you and your insurance company. If you do not notify us of changes in your coverage prior to any visit, you will be held responsible for the entire fee as many insurance companies have a timely filing period.

You are ultimately responsible for the timely payment of your account including any balance that may not be paid by your insurance company. In the event that your insurance company has not paid the FULL BALANCE in 60 days from the date of service; you will have 30 days to pay the remaining balance. It is *your* responsibility to contact your insurance regarding timely payment of claims. **Accounts over 90 days will be assessed a $75 processing fee and turned over to a collection agency.**

We accept all major credit cards, cash and personal checks processed through Telecheck.

Medicare

Kaur Psychiatric Associates, PA does not file claims with Medicare because we are not Medicare providers. If your primary insurance is Medicare, you will be responsible for the entire fee as Medicare will not accept a claim from a non-network provider. Medicare will also not allow you, the patient, to submit a claim on your own behalf. You agree not to file a claim to Medicare or to ask Kaur Psychiatric Associates, PA to file a claim for you. You also agree to the terms on the Patient Contract regarding Medicare and secondary insurance coverage.

Kaur Psychiatric Associates, PA does not file claims to Tricare or CHAMPUS. You may request a detailed receipt and file the claim yourself and request them to reimburse you directly.

RELEASE OF INFORMATION

I authorize Kaur Psychiatric Associates, PA to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to Kaur Psychiatric Associates, PA.

I HAVE READ, UNDERSTAND AND ACCEPT THE ABOVE TERMS AND CONDITIONS;

Signature:_____ Date:_____

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Client Information and Office Policy Statement
Informed Consent

I. **Welcome New Client!**

Thank you for choosing to enter treatment. This is an opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your psychiatrist will answer any questions you may have regarding any of these policies.

II. **Aims and Goals**

Our main goal is to help you identify the need of medication after a complete and thorough psychiatric evaluation, and to help you understand how the medication may work.

You are responsible for providing necessary information to facilitate effective treatment. You are expected to play an active role in your treatment, including working with your psychiatrist to outline your treatment goals and assess your progress. There may also be negative consequences if you do not follow through with recommended treatments(s).

III. **Appointment**

Appointments are scheduled for 45 minute initial evaluations and then for 15 minute follow-up appointments. The practices' hours are Monday-Thursday 8:30am-6:30pm and Friday 8:30am-5:00pm. Patients are generally seen back in 4-6 weeks as acuity dictates and you and your psychiatrist agree. You may discontinue your treatment at any time, but please discuss any decisions with your psychiatrist.

IV. **Emergencies**

In the event of an emergency, your psychiatrist may be reached by calling the office at (336)645-9555. If you are unable to reach your psychiatrist you may call your primary care physician or go to your local emergency room. To reach the doctor on call, *after hours*, and only in the event of a **life threatening emergency**, please call (336)691-2129.

V. **Confidentiality**

Issues discussed in your appointments are important and are generally legally protected as both confidential and "privileged". However, there are <u>limits to the privilege of confidentiality</u>. These situations include: 1) suspected abuse of neglect of a child, elderly or disabled person. 2)when your psychiatrist believes you are in danger of harming yourself or another person, or you are unable to care for yourself. 3) If you report that you intend to physically injure someone, the law requires your psychiatrist to inform that person as well as legal authorities. 4) If your psychiatrist is ordered by court to release information as part of a legal involvement in company litigation, etc. 5) when your insurance company is involved, e.g. filing a claim, insurance audits, case review, appeal, etc. 6) In natural disasters whereby protected information may become exposed or 7) When otherwise required by law. You may be asked to sign a release of information so that your psychiatrist may speak with other medical professionals or to family members.

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VI. **Record Keeping**

A clinical chart is maintained describing your condition, treatment and progress. This record also covers your dates of service, fees and noted describing each appointment. Your records will not be released without your written consent, unless in those situations previously outlined in the confidentiality section above. Medical records are locked and kept on site.

VII. **Fees**

The fee for the initial visit is $300.00
Each 15 minute session billed to insurance thereafter is $150/175. We offer a self-pay discount for follow-up visits in the amount of $140.
A minimum of $15 is assessed for completed paperwork.

VIII. **Payments**

Payment is due at the time of your appointment. We will file your insurance claim but you are responsible for any deductibles, coinsurance and copayments. It is your responsibility to familiarize yourself with your insurance benefits.

IX. **Cancellations and Missed Appointments**

You will be billed for an appointment that you cancel with less than 24 hours notice, or for an appointment that you fail to show up for. The charge for a missed or cancelled appointment is $60. There will be no copay charged as insurance companies do not reimburse failed appointments. Although we make reminder calls, appointments are your responsibility.

X. **Complaints**

You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your physician or any office policy, please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved you may also inform your insurance carrier and file a complaint, if you so choose.

XI. **Consent for Treatment**

By signing below, you are stating that you have read and understood this 2 page policy statement and you have had your questions answered to your satisfaction.

XII. **Controlled Substances and Prescriptions**

Controlled substance will not be filled early for any reason; this includes, but is not limited to: lost, theft, vacation or accidental destruction. We require 24-36 hours to process a refill.

I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation and/or treatment. I understand that I may withdraw from treatment at any time.

Name of Patient (Print):_____

Signature: _____

Date: _____

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Please initial if Medicare is NOT your primary insurance. _____

Contract for Patients with Medicare*

Please be advised; you, as the patient, have the right to services provided by another physician who is covered by Medicare, and has not opted out of the program.
As I am not a provider for the Medicare Program under code 1128 of the Social Security Act, you agree to the following:

You will be a private pay patient and agree to be responsible for all visits from this date forward, at the rate of $300.00 for an initial visit and $140.00 for medication management follow-up visits, once the self-pay discount has been assessed. By agreeing to this, you acknowledge that no reimbursement will be provided by Medicare, and also that our rates are not limited and subject to change at any time.

By signing this contract, you agree not to submit a claim or request us to submit a claim to Medicare for services that would normally be covered. Also, you acknowledge that Medicap plans and other supplemental insurance plans may choose not to make payments for services furnished by me when Medicare is the primary payor and a claim cannot be submitted to Medicare for payment.

You also acknowledge the office policy of Kaur Psychiatric Associates to file only primary insurance. If you, the patient, have dual insurance coverage, our office will not file a claim to the secondary insurance provider.

By signing this contract, you agree to the above terms and conditions.

_____ _____

Rupinder Kaur, M.D. Patient Signature

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Written Acknowledgement Form

Our Notice of Privacy Practices provides information about how we may use and disclose information about you. As provided in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy.

I, _____ (please print patient name) have been provided with a copy of Kaur Psychiatric Associates, PA Notice of Privacy Practices.

I have had an opportunity to read the Notice of Privacy Practices.

I understand that I may ask questions to Kaur Psychiatric Associates, PA if I do not understand any information contained in the Notice of Privacy Practices.

_____ _____

Patient Signature or Signature of Authorized Representative of Patient — Date

_____

Relationship to Patient