215 Rue Fontaine
Lafayette, Louisiana 70508
605 South Lewis Street
New Iberia, Louisiana 70560
Phone: 337-889-3682
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Novas
PSYCHIATRIC SERVICES

Date:_____

Patient's Full Name:_____ DOB:_____
Address:_____City:_____State:_____ Zip:_____
Cell (Text reminders):_____ Home:_____ Work:_____
(You will receive a text message 24 hours before scheduled appointment)
SSN:_____ Sex:_____Male _____Female
Name of school **(If in school)** :_____ Grade:_____
Employer:_____ Phone #:_____
Address:_____ Occupation:_____

Primary Insurance

Carrier Name:_____Subscriber Information Name:_____
Member ID #:_____Relationship to Subscriber:___Self___Spouse___Child

Secondary Insurance

Carrier Name:_____Subscriber Information Name:_____
Member ID #:_____Relationship to Subscriber:___Self___Spouse___Child

Appointed Pharmacy

Pharmacy:_____ Phone:_____
Address:_____City:_____ State:_____ Zip:_____

Allergies to Medications:_____
_____

List of medicines currently taking:_____
_____

Family Physician:_____

Emergency Information

Name:_____ Relationship:_____Phone:_____
Spouse/Partner Name:_____ Phone:_____

I understand that my signature below certifies the information to Novas is accurate and current.

_____ _____
Signature of Patient or Guardian (if minor) **Date**

24 Hour Cancellation and No Show Appointment Policy

Novas provides a courtesy call to remind patients of their appointments. It is the responsibility of the patient to call or cancel within **24 hours** of the schedules appointment to avoid a no-show charge of $50.00 for follow-ups and $100.00 for new patients to be paid in full by cash or credit card before the next visit can be scheduled. If your contact information changes between visits, it is the responsibility of the patient to contact our office to avoid any fees. Any outstanding fees must be paid before seeing **ANY** provider within Novas.

There are circumstances that exceptions may be made to this policy upon the discretion of the provider.
After two (2) no show appointments, the patient will be given warning of discharge for noncompliance up the third (3) no show.

This policy is in place out of respect for our psychiatrist and out patients. Cancellations with less than 24 hour notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone from being able to schedule into the time slot.

_____ (Patient Initials) "NO SHOW" fees will be the responsibility to the patient. This fee is NOT covered by insurance and must be paid prior to your next appointment. Three or more "no shows" in any 12 month period may result in termination from our practice.

By signing below, you acknowledge that you have read and understand the cancellation policy to its fullest for NOVAS as described above.

Thanks kindly in advance for your cooperation.

_____ _____

Signature Date

Patient HIPAA Acknowledgment and Consent Form

Patient Name:_____ DOB:_____

_____ (Patient Initials) **Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare for its treatment, payment, healthcare, operations and other described and permitted uses and disclosures. I understand that I may contact the privacy officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practice's.

_____ (Patient Initials) **Release of Information.** I hereby permit practice and the physicians or other professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designer when the services delivered and related to a claim under worker's compensation.
- If I am covered by Medicaid or Medicare, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a medicare claim or to the appropriate state agency for laboratory reports operative reports, physicians progress notes, nurse's notes, consultations, psychological and/or psychiatric reports\ drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family members
DO YOU WANT TO DESIGNEE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?

I give permission to my Protected Health Information to be disclosed for purposes of communicating results, finding and care decisions to the family members and others listed below:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification MUST be in writing.

HIPPA Notice of Privacy Practices

This notice describes how medical information may be used and disclosed and how you can get access to this information. Please review carefully.

This notice of privacy practices describes how we may use and disclose your protected information (PPHI) to carry out treatment, payment or healthcare operation and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protect Health Information" is information about you or future physical or medical health or condition and related to health care services.

Use and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your provider. Our office staff and others outside of our office that are involved in your case and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physicians practice and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination of management of your healthcare with third party. For example, your protected health information may be provided to a provider to whom you have been referred to ensure that the provider has necessary information to diagnose and treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for healthcare services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect, Food and Drug Administration requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Military Activity and National Security, Worker's Compensation. We must make disclosures to you and when required by the Secretary of the Department of Health and Human Service to investigate or determine our compliance with the requirements of Section 164.500

Other permitted and required uses and disclosures: Will be made only with the consent, authorization and opportunity to reject unless required by law. You must revoke this authorization at any time in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights: You have the right to review your protected health information. Under federal law however, you may not review or copy the information complied in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment, or health operations.

Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit, use and disclose of your protected health information, your protected health information will no be restricted. You then have the right to use another healthcare professional.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

You may have the right to have your provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or with draw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy officer:

HIPPA Privacy Officer

call us at: (337)889-3682

We will not retaliate against you for filing a complaint. This notice was published and becomes effective on/or before February 2012. We are required by law to maintain the privacy of, and provide with, this notice of out legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA compliance officer in person or by phone.

Consent for Treatment: I authorize Novas staff and attending providers to render to the patient all customary care, therapy, treatment,

considered advisable, including emergency treatment and transportation to another facility if necessary.

The undersigned acknowledge that the patient is under the care of a provider and Novas are not liable for any act or omission in the following the instructions of said provider(s). The undersigned recognized that certain healthcare professionals furnishing services to patient, including but not limited to. Nurse Practitioners, and/or social workers that are independent contractors and or not employees or agents of Novas. The undersigned further recognizes that the patient is responsible for any health insurance deductible, federally mandated co-insurance, and non-covered charges for the provider(s).

Consent for Release of Information: I authorize Novas to release all patient information, including specific information regarding diagnosis, treatment and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which patient is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while patient of Novas to any insurance company, and/or third party payors, or representative providing coverage for services, to any appropriate representative of Novas including, but not limited to employees (as applicable by HIPPA laws, attending providers, other healthcare professionals or organizations. This information may not be released to any other person or entity **unless** the undersigned so authorizes.

I acknowledge that such disclosure shall be limited to information that is responsible necessary for the billing of the legal or contractual obligations of the person(s) or entities to which information is released.

I further authorize, Novas to release information for the purpose of obtaining pre-authorization for treatment to release the information to medical review agencies, and/or third party payors providing coverage or having responsibility for these services.

Guarantee of Payment/Financial Responsibility: I, hereby agree to guarantee the payment of the bill for services rendered by Novas. I agree whether signing as guarantor or as a patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account in accordance with the regular rates and terms of Novas. I agree that I am responsible for any health insurance deductible, federally mandated co-insurance, and non-covered charges. Should the account be referred for collection by an attorney or collection agency, the undersigned agree(s) to pay all attorney's fees and other reasonable collection costs and charges that are necessary for the collection of any amount(s) not paid when due.

Assignment of Insurance Benefits: In consideration of medical services rendered or to be rendered by Novas to the extent permitted by law. I hereby (I) Irrevocable assign, transfer and set over the Novas (II) all of my rights, title and interest to medical reimbursement, including, but not limited to, (III) the right to designate a beneficiary, add dependent eligibility and (IV) to have an individual policy continued or issue in accordance with terms and benefits under any insurance policy subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered by the cooperation during the pen ency of the claim. Such irrevocable assignment and transfer shall be for the recovery on said policy and policies of insurance, but shall not be construed to be an obligation of cooperation to pursue any such right of recovery. I hereby authorize the insurance company or companies third party pay or(s) to pay directly to Novas all benefits due for services rendered.

Acknowledge of Receipt of HIPPA Privacy Practices: I individually or as the personal representative of the patient, acknowledge that I was given a copy of Novas Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can get access to this information.

I understand that my signature below certifies that the information provided to Novas is true and correct to the best of my knowledge. I have read and understand the above consents and/or statements.

_____

Print Patient Name

_____

Signature of patient or Guardian (if minor) Date

Credit Card Authorization Form (Keep on File)

This form is for you to supply Novas with credit card information to keep on file for the payment of all services and fees.

Fees can include but are not limited to:

- Office visit fee
- Co-payment fee
- Late or no show fee as per office policy
- Lab fee
- Office form request fee
- Request form record fee

A new form must be completed for each card kept on file. Novas accepts Visa, Discover, Mastercard, American Express.

Card Information

Card Type **(Circle):** Visa Mastercard Discover American Express

Name on Card:_____

Card Number:_____

Exp. Date:_____ CV code (# on the back of the card):_____

Cardholder Signature:_____ Date:_____

Please list anyone other than the cardholder that is authorized to use this credit card

Name:_____ Signature:_____

Please accompany this form with a copy of your driver's license or photo ID as well as for any and all parties listed above.

I authorize **NOVAS** to charge the credit card listed above for payment for all services and fees. This credit card will be kept on file and will remain in effect until expiration of the credit card account. Applicants may revoke this credit care on file by submitting a written request to the address at the top of this form. A new form must be submitted if any information such as credit card expiration or authorized users is amended. Applicants agree to pay the cost for any returned or challenged payments.

Client Signature:_____ **Date:**_____

Informed Consent for Tele-Medicine Services

Patient Name:_____ Date:_____

Address: _____

- I understand that tele-medicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he/she is located at a different site than the provider; and hereby consent to Novas providing healthcare service to me via tele-medicine.
- I understand that the law protects the privacy and confidentiality of medial information that also apply to tele-medicine. As always, your insurance carrier will have access to your medical records for quality review/audit. Should need medical records, please contact our office at **(337)889-3682**
- I understand tat I will be responsible for any co-payments or co-insurances that apply to my tele-medicine visit.
- In the event of a technology failure, please call our office to schedule an appointment. If it's an emergency, please go to the local hospital or call our office during business hours at **(337)889-3682**
- I understand that I have the right to withhold or withdraw my consent to the use of tele-medicine in the course of my care at any time, without affecting my right to future care or treatment.

As long as this consent is in force (has not been revoked) Novas may provide healthcare services to me via tele-medicine without the need for me to sign another consent form.

_____ _____

Signature Date

Patient Health Questionnaire (PHQ-9)

Name:_____ Date:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
(use a "check mark" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly Everyday
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Felling bad about yourself- or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite- being so figety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself.	0	1	2	3
Add columns				

(Healthcare professional: For interpretation of TOTAL, please refer to accompany scoring card).

TOTAL:_____

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Felling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column		+	+	+
Total Score (*add your column scores*)=				

If you check off any problems, how difficult have these make it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Scoring

Scores of 5, 10, and 15 are taken as the cut-off points or mild, moderate and severe anxiety, respectively, when used as a screening took, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately food at screening three other common anxiety disorders- panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med. 2006; 166: 1092-1097*

How Common is Bipolar Disorder?
The Mood Disorder Questionnaire

Answer each of the following questions to the best of your ability, then talk with your healthcare provider.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
.....you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	____	____
....you were so irritable that you shouted at people or started fights or arguments?	____	____
....you felt much more self-confident than usual?	____	____
....you got much less sleep than usual and found you didn't really miss it?	____	____
....you were much more talkative or spoke much faster than usual?	____	____
....thoughts raced through your head or you couldn't slow your mind down?	____	____
....you were so easily distracted by things around you that you had trouble concentrating or staying on track?	____	____
....you had much more energy than usual?	____	____
....you were much more active or did many more things than usual?	____	____
....you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	____	____
....you were much more interested in sex than usual?	____	____
....you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	____	____
....spending money got you or your family into trouble?	____	____
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	____	____

3. How much of a problem did any of these cause you- like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

_____ No problem _____Minor problem _____Moderate problem _____Serious problem

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool. Always consult with you healthcare provider.

SUNOVION