BRIGHTER DAYS MENTAL HEALTH SERVICES LLC
CLIENT INFORMATION RECORD

PLEASE COMPLETE FORM IN ITS ENTIRETY-PLEASE PRINT

PROVIDER LaToya Bragg, MSN, APRN, PMHNP-BC

PATIENT NAME: ______________________________ DOB: ________________

SOCIAL SECURITY NUMBER: ______________________________

ADDRESS: ______________________________

____

CITY: ____________________ STATE: __________ ZIP: ______________

HOME PHONE: __________________ WORK PHONE: ____________________

CELL PHONE: __________________ EMERGENCY PHONE: ________________

MARITAL STATUS: ____________ MALE: __________ FEMALE: ___________

IF PATIENT IS A MINOR, NAME OF PARENT/GUARDIAN SIGNING PAPERWORK AND SOCIAL SECURITY #

NAME______________________________SS#__________________

INSURANCE____________________ ACTIVE: YES___ NO ___ COBRA_____

NEAREST FRIEND/RELATIVE NOT LIVING WITH YOU: ____________________

PHONE: ________________ RELATIONSHIP: ________________________

WHO REFERRED YOU TO OUR OFFICE? ______________________________

EMPLOYER: ______________________ POSITION: ____________________

I VERIFY THAT THIS INFORMATION IS CURRENT AND ACCURATE.

______________________________ ______________________________

SIGNATURE **DATE**

BRIGHTER DAYS MENTAL HEALTH SERVICES LLC
PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by the Brighter Days Mental Health Services LLC, (hereinafter referred to as ("BDMHS") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of BDMHS. I understand that diagnosis by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. BDMHS is not required to agree to the restrictions that I may request. However, if BDMHS agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that BDMHS has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the BDMHS 's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of BDMHS. The Notice of Privacy Practices also describes my rights and BDMHS' duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

BDMHS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my appointment.

____________________________ ____________________________

Patient or Responsible Party **Date**

BRIGHTER DAYS MENTAL HEALTH SERVICES LLC
INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, Psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else;
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse;
- The client is required to undergo a court-ordered examination;
- The client discloses information about abuse, neglect, or exploitation of a minor;
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult;
- The client's mental or emotional condition is used as a legal defense;
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action.

I hereby give my consent for service to be provided under these conditions.

______________________________ ______________________________

Signature **Date**

BRIGHTER DAYS MENTAL HEALTH SERVICES, LLC
FINANCIAL POLICIES

- Your co-payment, deductible or any non-covered charge is due at the time of service.
- Your insurance card(s) may be copied each time you are seen. We must verify the correct insurance information at each visit.
- Benefits quoted by your insurance company are NOT a guarantee of payment. **You will be asked to pay any charges not paid by your insurance company.**
- We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.
- Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement.
- You are responsible for confirming with your insurance company that the providers you are seeing are in your network. **This office does not file claims out of network**.
- You will be billed $35 for late cancellations and $50 for a missed appointment without 24 hours' notice.
- You may be billed up to $100 for all letters you request and up to $200 for all forms you request.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agree to be liable for any costs incurred in the collection of any unpaid balance, including any and all reasonable attorney fees. I understand a finance charge of $50.00 will be assessed if my account is turned over to a collection agency.

______________________________ ______________________________

Patient or Responsible Party **Date**

I authorize BRIGHTER DAYS MENTAL HEALTH SERVICES, LLC to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to BRIGHTER DAYS MENTAL HEALTH SERVICES, LLC.

______________________________ ______________________________

Patient or Responsible Party **Date**

BRIGHTER DAYS MENTAL HEALTH SERVICES, LLC

Controlled Substance Contract

Patient Responsibility

1) I agree to take any Controlled Substances exactly as instructed. I am NOT allowed to change the dose or number of times per day that I take my medication without first talking to my Controlled Substances Provider. ____(initial)

2) I agree to only take Controlled Substances prescribed by ____________________ **(Brighter Days Mental Health Services, LLC)** _____ (initial)

3) I will not take Controlled Substances written by another provider or specialist unless I have notified my provider prior to filling the prescription. _____ (initial)

4) I agree to safekeeping my Controlled Substance prescriptions and medications. I understand that lost,

misplaced, or stolen prescriptions or medications will not be replaced. _____ (initial)

5) I will bring in all my Controlled Substance medications in their original pill container to every appointment if requested by provider _____(initial)

6) I will bring in all Controlled Substance medications in their original pill container for random pill counts within 24 hours when requested _____ (initial)

7) I will NOT combine any narcotic medication with consumption of alcohol. Any UDS that is positive for both Controlled Substances and alcohol will be considered a violation of this contract. _____ (initial)

8) I will NOT combine any narcotic medication with illegal/street/recreational drugs. Any UDS that is positive for both prescribed Controlled Substances and illicit substances will be considered a violation of this contract. _____ (initial)

9) I will be responsible for making and keeping appointments for Controlled Substance refills at least every 3 months. I understand that NO refills will be written outside of my appointment and I will NOT contact the office for refills of these medications. _____ (initial)

10) I will be responsible for having a working phone number which the office will use to contact me about random UDS and pill counts. I understand that once notified by the office, either directly or by voicemail, I will have 24 hours to report, or inability to do so will result in a violation of this contract. _____ (initial)

11) I understand that not all insurances cover the cost of Drug Screening and that I may be responsible for part or the entire bill. _____ (initial)

12) I understand that I will not receive any Controlled Substances until my provider has been able to review my medical records. If I am a new patient, I understand that it is my responsibility to ensure my medical records have been obtained from my previous provider. _____ (initial)

13) I will not lie or tell misleading information to my provider or any of the Brighter Days Mental Health Services, LLC staff. _____ (initial)

14) I will not get angry or make threatening remarks in an attempt to get Controlled Substances _____ (initial)

Provider Responsibility

1) I will provide the best evidence based care for your condition based on the medical and/or psychiatric condition being treated _____ (initial)

2) I will help set functional goals with you _____ (initial)

3) I will obtain a random drug screen at least once a year (may be from blood, urine, saliva based on provider discretion) _____ (initial)

4) I will only refill controlled substances at your designated medication refill appointment _____ (initial)

5) I will obtain at every appointment a report from Virginia Prescription Monitoring Program (VAPMP) which shows all controlled substances you have been prescribed including:

a. Who wrote the script _____ (initial)

b. Which pharmacy filled the script _____ (initial)

c. What medication, dose and quantity were filled _____ (initial)

6) I will assess the risk/benefit/safety of your medications including:

a. Side effects _____ (initial)

b. Functional abilities _____ (initial)

c. Pain control (if applicable)_____ (initial)

d. Anxiety scale _________ (initial)

Consequences of NOT adhering to any part of this Contract:

1) Our office/providers will no longer:

a. Prescribe any controlled substance for you. It will be at provider discretion to decide if a taper of

medication will be given. _____ (initial)

b. May stop providing medical care for you _____ (initial)

c. May refer you for drug abuse treatment _____ (initial)

Consequences of NOT signing this contract:

1) We will not prescribe controlled substances for you. _____ (initial)

Should you be discharged from our practice due to breakdown of provider/patient communication, your provider will provide 30 days of care from the date of discharge. This may not apply to Controlled Substances if the reason for discharge was a violation of this contract.

SIGNATURES

Date: ________________ Time: ___________

Patient Signature: ____

Print First Name: __________________________ Last____

Date: ________________ Time: ___________

Provider Signature: ____

Print Provider Name: ______________________________________