Practice Policies and Authorization for Treatment and Payment

Please read the following practice policies carefully and keep a copy for your record. If you have any questions regarding any of these policies, please feel free to discuss them with the Practice Manager.

The "Practice" refers to Kraus Behavioral Health, LLC; its associates, employees, and contractors.

1. **Services**: Kraus Behavioral Health provides psychiatric medication management and brief psychotherapy for patients.

2. **Office Hours**: Office hours are held Monday through Friday from 9:00 AM to 5:00 PM. Patients are seen by appointment only. If you are experiencing a psychiatric emergency, please call 911 or go to the nearest emergency room for urgent treatment.

3. **Appointments:** Initial evaluation appointments are scheduled for approximately forty-five (45) minutes to one (1) hour with follow-up appointments generally scheduled for fifteen (15) to thirty (30) minutes.

4. **After Hour Policy:** If non-emergent questions or concerns arise after hours, during the weekend, or holidays, you may call the office phone number and leave a voicemail message. After-hours calls will be answered within 48 hours. However, if you have an emergency related to your mental health condition, treatment, or medication, please call 911 or go to the nearest hospital emergency room.

5. **Contact Information**: It is important to have your correct contact information on file. Please advise us anytime there is any change to your mailing address, telephone number, or contact information.

6. **Insurance**: Kraus Behavioral Health participates in several insurance plans including Medicare, Medicaid, Managed Care and Commercial plans. Although the Practice accepts assignment with Medicare and Medicaid and may accept assignment (i.e. reimbursement rates) with other payors, it is your responsibility to know your insurance coverage and benefits. If your insurance carrier is not one with which we participate, you are responsible for payment in full. **Insurance plans determine service fees, such as co-payments, co-insurance, and deductibles. Balances not covered by your insurance plan are your responsibility**. If you are uncertain about your current health insurance policy benefits, you should contact your plan directly to learn the details of your benefits. Insurance companies may take 30 to 90 days to process a claim; once a claim has been processed, any remaining balance will be the patient's responsibility. You must present a current insurance card at each visit. If you do not have insurance coverage, a schedule of fees for out-of-pocket payment may be requested. Out-of-pocket fees are due at time of service.

7. **Payment:** Payment is expected at time of service, unless prior arrangements have been made, and is accepted in the form of check, VISA, Mastercard, or American Express. Also, payment of any outstanding balance is expected at time of service. Checks returned for insufficient funds will be subject to a $35.00 processing fee. Checks should be made payable to: *Kraus Behavioral Health*

8. **Billing**: The Practice will obtain insurance pre-authorizations required for visits. By signing this policy, you authorize Kraus Behavioral Health to release to your insurance company any information needed to process your claim and/or determine benefits payable for related services. If the insurance company does not pay for the billed session(s), the patient/guardian will be responsible for paying the balance. Statements are mailed on a monthly basis and payment is due upon receipt of your statement. Past due accounts may hinder your ability to schedule future appointments. In addition, if your account becomes delinquent, the practitioner, his/her assigns, or lawful agents may pursue collection procedures. **You will be responsible for all collection costs including and not limited to court filing fees, service of procedure costs, interest, and attorney fees. Note:** *You are responsible for updating Kraus Behavioral Health with correct phone number, billing address, and insurance information.*

**Policies continued on next page. Please read and SIGN*→*

9. **Late Cancellations/No Shows**: *See Late Cancellation/No Show Policy*

10. **Confidentiality/Privacy/HIPAA**: Kraus Behavioral Health follows both the federally mandated privacy laws (HIPAA) and Maryland laws. This Practice further recognizes that the patient's protected health information, as described in this Practice's Notice of Privacy Practices (NPP), is privileged and as such any information can only be released for the purposes of treatment, payment, or health care operations, as outlined in this Practice's NPP (please read the Notice of Privacy Practices for more information). Your personal health information and all communications between you and the practitioner are held strictly confidential, with the exception of where the clinician is requested by law to inform authorities and/or potential victims such as: 1. The patient presents a danger to herself/himself or others 2. Child/elderly/disabled adult abuse/neglect is suspected and/or 3. The practitioner is ordered by a court to disclose information about you in the course of a judicial or legal proceeding.

11. **Medical Records Release:** Per HIPAA guidelines, medical record requests must be made in writing. To ensure your privacy, a form for release of protected health information must be completed prior to transfer or receipt of these materials. This practice will make every effort to respond to requests in a timely manner; however, compiling medical records may take up to three weeks to process. A processing fee may apply and is due prior to the release of the records.

12. **Forms and Letters**: Please allow 7-10 business days for the completion of any forms or letters requests. *Please note: Disability forms are only completed for patients who have been a consistent patient of Kraus Behavioral Health for greater than 6 months. Disability forms will not be completed for patients of less than 6 months.* Processing fees may apply for all forms/letters and are due prior to the completion of the request.

13. **Prescription Refills and Pharmacy Policy**: Please inform this practice of which pharmacy you use and update us if this should change**. Review medications prior to your appointment and request refills at that time if needed.** Please allow two to three business days for refill requests requested by phone (*patients may be required to be seen by the practitioner prior to authorization of refills*).

14. **Consent to Treatment**: By registering with this Practice, the patient's signature below represents agreement to be treated by the Practice. You give permission to the Practice to use clinical data for educational or research purposes, recognizing that any personally identifying information will be protected, consistent with standard PHI and HIPAA policies.

15. **Assignment of Benefits**: The signature below authorizes payment from the patient's insurance company for medical services to be made directly to Kraus Behavioral Health. It further authorizes Kraus Behavioral Health to contact the patient's insurance plan and/or managed care company for the purpose of obtaining benefit information, treatment plans, and billing requirements.

I, _____, have read and understand the above policies for the
(Print Patient Name or Responsible Party)
practice of Kraus Behavioral Health. *I further acknowledge that I have received a copy of the Practice's Notice of Privacy Practice, and/or am aware that it can be found and downloaded from www.krausbehavioralhealth.com, and/or can request a copy at the time of my appointment.* I agree that I have been given the opportunity to ask questions and seek clarification on all aspects of the above information. Finally, I agree that I will adhere to these policies as outlined above.

	Patient or Responsible Party's Signature	***Date***
**If Applicable,* *Verbal Consent By:*	**Patient or Responsible Party**	**Date and Time**

Please notify receptionist if you would like a copy of this form for your records.

Patient Information Form

Kraus BEHAVIORAL HEALTH

Date: _____

PATIENT INFORMATION

Patient Name (First, Middle, Last Name): _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: _____ Social Security Number: _____

Gender: _____ Ethnicity: _____

Religion *(optional):* _____ Marital Status: Single Married Divorced Widowed Other

If Applicable, Partner/Spouse Name: _____ - If Other, please describe: _____

Military: ☐ Yes ☐ No Dates Served: _____

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Other: _____

If disabled status, please indicate disability: _____

Employer Name: _____ Occupation: _____

Does the patient have a **Legal Guardian** or **Healthcare Power Of Attorney** (POA)?*****: ☐ Yes ☐ No

Guardian/POA Name: _____ Guardian/POA Contact Number: _____

Address for Bills *(*if applicable):* _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Phone Number: _____

**POA or Legal Guardian must Sign Paperwork; Complete address if responsible for receiving and paying patient bills.*

INSURANCE INFORMATION

Primary Policy Holder: ☐ Self ☐ Spouse ☐ Other (specify): _____

Primary Subscriber Name *(if different from patient):* _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Birthdate: _____

Social Security Number: _____

PRIMARY Insurance Name: _____

Member/Subscriber ID Number: _____ Group Number: _____

SECONDARY Insurance Name: _____

Member/Subscriber ID Number: _____ Group Number: _____

Kraus Behavioral Health, LLC.

PATIENT CANCELLATION
AND NO-SHOW POLICY

Kraus Behavioral Health, LLC. is committed to providing exceptional, quality care; however, this is impossible without consistent follow-up visits with your Kraus Behavioral Health provider. No- shows and late cancellations are costly to the practice and limit access to care for other patients. Your appointment time has been reserved for you; therefore, please have the courtesy to attend your follow-up visits as scheduled. If you cannot keep your appointment, contact us to cancel/reschedule in accordance with practice policy.

Kraus Behavioral Health Patient Cancellation and No-Show*^ Policy:

1. **All late cancellations and no-show appointments** are subject to a **$65.00 fee** and will be billed to the patient.
    - ***Appointment Reminder calls/texts are ***only courtesy*** reminders- It is ultimately the ***patient's responsibility*** to know the time/date/location of his/her scheduled appointments. If you cannot recall the time/date/location of your next appointment, it is your responsibility to contact the main office to confirm your next scheduled appointment.

2. After 3 missed scheduled appointments (within a consecutive 12-month period), the patient will be discharged from the practice.

It is the patient's responsibility to notify Kraus Behavioral Health of a cancellation *at least 24 hours (1 day) in advance of the scheduled appointment to avoid the late cancellation and no-show fee.* Appointments cancelled less than 24 hours in advance are considered a no-show and will be charged the $65.00 fee.

** No shows are calculated based on a consecutive 12-month period.*
^This fee does not apply to Medicaid patients.

Please arrive 15 minutes prior to your appointment to complete the check-in process. If you arrive after your scheduled appointment time, you may be asked to reschedule and be charged a no-show fee.

NOTE: *Emergencies arise from time to time and a late cancellation cannot be avoided. The Kraus Behavioral Health management team will review emergency situations on a case-by-case basis.*

I have read and understand the Kraus Behavioral Health patient cancellation and no-show policy:

_____

Patient Name (PRINT)

_____ _____

Patient Name (SIGN) ***Date***

Please notify receptionist if you would like a copy of this form for your records.

Kraus Behavioral Health, LLC.

Patient Contact Consent Form

Kraus Behavioral Health may communicate with you regarding upcoming scheduled appointments and other services. By signing this form, you understand you may be charged for such calls by your wireless carrier and that such calls may be generated by an automated dialing system. *This consent will remain in effect until terminated by you in writing.*

Circle Yes or No:

Yes	No	May we text or email you to confirm appointments?
Yes	No	May we phone you to confirm appointments?
Yes	No	May we leave a message on your answering machine on your phone?
Yes	No	May we leave a message regarding your appointment with anyone*?

I authorize the following persons to receive information regarding my appointment/billing/payments:

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

NOTES:

_____ _____

Patient's Name (Please Print) **Date of Birth**

_____ _____

Patient's Signature ***Date***

or ***(Patient Representative's Signature & Relationship)***

Please notify receptionist if you would like a copy of this form for your records.

Psychiatric Questionnaire

Please complete in its entirety.

(Additional space is available on the last page if required for any portion of the questionnaire.)

Patient Name: _____ **Date:** _____

Please briefly describe the problems/symptoms for which you are seeking help today:

_____

_____

_____

How did you hear about Kraus Behavioral Health? *(*Referral's name and relation to you, if applicable)*:

_____

PSYCHIATRIC INFORMATION AND HISTORY

Have you ever received *OUTPATIENT* psychiatric treatment? ☐ No ☐ Yes

Clinician/Doctor Name	When?/How long?	Reason Why You're No Longer Seeing Them

Have you ever received *INPATIENT* mental health treatment? ☐ No ☐ Yes

Hospital Name	Dates of Treatment	Reason for Hospitalization

Current *PSYCHIATRIC* Medications
*(*if applicable)*

Medication Name	Dose	Frequency	Condition	Estimated Start Date	Prescriber's Name

Have you tried any *psychiatric* medications in the *past*? ☐ No ☐ Yes

If Yes, please list below:

Medication Name	Dose	Frequency	Estimated Start-End Dates	Reason Why You No Longer Take It

Are you currently seeing a Therapist? ☐ No ☐ Yes

If Yes: Therapist's Name: _____ How often do you see him/her? _____

Have you ever threatened or attempted suicide? ☐ No ☐ Yes

If Yes, please describe: _____

Have you ever tried to harm yourself? ☐ No ☐ Yes

If Yes, please describe: _____

Do you have a history of violence? ☐ No ☐ Yes

If Yes, please describe: _____

Has anyone in your Family been diagnosed/treated for a *psychiatric* condition? ☐ No ☐ Yes

If Yes, please describe the Family Member's relation to you and What they were treated for? _____

_____

Substance Use

Tobacco Use (Smoking/e-cig)**:** ☐ No ☐ Former ☐ Yes Packs Per Day: _____ # of Years: _____

Tobacco Use (Smokeless)**:** ☐ No ☐ Yes Brand: _____ # of Years: _____

Alcohol: ☐ No ☐ Yes How many drinks a week: _____

Marijuana: ☐ No ☐ Yes How often: _____

- *Prescribed?* ☐ No ☐ Yes By Whom? _____

Other Illicit Drugs? ☐ No ☐ Yes *(please list)*: _____

_____

Have you ever been treated for alcohol or drug abuse? ☐ No ☐ Yes

If Yes, for which Substances? _____

If Yes, Where and When were you treated? _____

SOCIAL HISTORY

Where were you Born/Raised? _____

What is your Highest Level of Education? _____

Have you ever been Physically or Sexually Abused? ☐ No ☐ Yes

If Yes, by Whom? _____ *When?* _____ *Was it reported?* _____

Current Living Situation *(check all that apply)***:**

☐ Alone ☐ With Spouse ☐ With Children ☐ With Parents ☐ Other: _____

Children? ☐ No ☐ Yes How many? _____

Have you ever been arrested? ☐ No ☐ Yes

If Yes, please explain: _____

Have you ever been charged legally? ☐ No ☐ Yes

If Yes, please explain: _____

Do you currently have any pending legal charges? ☐ No ☐ Yes

If Yes, please explain: _____

MEDICAL HISTORY

Primary Care Provider Name: _____ **Phone #:** _____

When was your last full/annual Physical Examination? *(Month/Year):* _____

When did you last have Bloodwork done? _____

Current Medical Problems/Diagnoses: ☐ None

_____ _____ _____

_____ _____ _____

Past Procedures/Surgeries: ☐ None

Please list the type of Procedure/Surgery and (Date) of the Procedure/Surgery: Ex—"Wisdom Teeth (2010)"

_____ _____

_____ _____

_____ _____

Current *NON-Psychiatric* Medications
(Please include over-the-counter supplements)

Medication Name	Dose	Frequency	Condition	Estimated Start Date	Prescriber

Allergies? (*check all that apply)* ☐ None ☐ Seasonal Allergies ☐ Drug Allergies

If Drug allergies, please specify the drug(s) below:

_____ _____ _____

_____ _____ _____

Pharmacy

Pharmacy Name: _____ Phone #: _____

Pharmacy Address: _____ Fax #: _____

Additional Space: