Please carefully review your information below and make any necessary changes on the back of this form.

Patient/ Guardian Email Address: _____

Per HIPPA Privacy Policy I, _____, authorize BPC and its professional, clerical, and billing staff members to contact persons listed below regarding any appointment, medical (emergent and non-or not), and billing issues.

Name:	**Relationship:**	**Home Phone:**	**Cell Phone:**
_____	_____	(____) _____	(____) _____
_____	_____	(____) _____	(____) _____
_____	_____	(____) _____	(____) _____

NOTICE TO ALL CLIENTS

****Effective 01/18/19 Please note the following changes to our Cancelation / No-Show Policy:**

The office requires at least a 24-hour notice of appointment cancelation. Failure to provide at least 24-hour notice of appointment and/or no-show for an appointment will result in the following charges:

MD:	15 minute appointment $50 charge	30 minute appointment $100 charge	45 minute appointment $150 charge
Therapist	1 missed appointment $50	2 missed appointment $100	3 + missed appointment – Full Fees

Our cancelation policy will be strictly enforced. The cancelation/no-show charge cannot be billed to your insurance company. You will be responsible for paying the fee prior to being rescheduled. In addition, if you miss 2 or more consecutive appointments, you may be discharged from the practice for non-compliance.

Your signature below authorizes and confirms: 1) BPC and its representatives may call the person listed above when necessary. 2) Updated information has been provided to our office. 3) You understand the Cancelation / No-Show Policy / Financial policy 4) Patient-Provider Specialty Agreement has been provided and aware it's available on office website: www.bpcpc.com

Patient / Guardian Signature: Date:

BIOLOGICAL PSYCHIATRY CENTER, P.C. **PATIENT DEMOGRAPHIC UPDATE FORM**

DATE: _____/_____/_____ **PATIENT NUMBER:** _____

Last Name:_____ **First Name**:_____ **Middle Name**:_____

Address:_____**City**:_____ **State**:_____ **Zip code**:_____

Cell #: (____)_____ **Home #**: (____)_____ **Alt #:** (____)_____

Our office utilizes HIPAA compliant programs to send appointment links, appointment reminders, payment links and payment reminders as a way to communicate with patients. May we text you at the number listed above? Yes / No

E-Mail: _____ **Date of Birth:** _____ /_____ / _____ **Social Security #:** _____/_____/_____

Employed: Yes / No **Employment Status:** Part-Time / Full-Time / Retired / Other: _____ **Employer**:_____

Family Doctor: _____ **Phone#:** (____)_____ **Address**: _____

Neurologist: _____ **Phone#:** (____)_____ **Address**: _____

Mental Health Therapist:_____ **Phone#:** (____)_____

REQUIRED FOR MINORS:

Fathers Name: _____ **DOB:** ____/____/_____ **Cell#:** (____)_____ **Home#**: (___)_____

Mothers Name: _____ **DOB:** ____/____/_____ **Cell#:** (____)_____ **Home#**: (___)_____

School Name: _____ **Phone#:** (____)_____ **Counselor**: _____

Address: _____ **Accommodations in Place:** IEP / 504 / Other:_____

INSURANCE INFORMATION:

Email Copy of ID and Cards to: forms@bpcpc.com

Primary Insurance: Policy Holder Name:_____ **Policy Holder DOB:**____/___/____

Name of Insurance Carrier:_____ **ID#:** _____ **Grp#:** _____

Secondary Insurance: Policy Holder Name:_____ **Policy Holder DOB:**____/___/____

Name of Insurance Carrier:_____ **ID#:** _____ **Grp#:** _____

Tertiary Insurance: Policy Holder Name:_____ **Policy Holder DOB:**____/___/____

Name of Insurance Carrier:_____ **ID#:** _____ **Grp#:** _____

PHARMACY INFORMATION:

Mail Away Pharmacy Name:	**Address:**	**Phone: ( )**
Local Pharmacy Name:	**Address:**	**Phone: ( )**

FORMS GIVEN BY BPC STAFF: (Annually)

- Patient-Provider Partnership Agreement: _____ (Please Initial) / Financial Policy: _____ (Please Initial)

- HIPAA Privacy Policy: _____ (Please Initial) / Telehealth Consent of Treatment: _____ (Please Initial)

EMERGENCY NOTIFICATION - In Case of Emergency Notify:

Name: _____ **Relationship**: _____

Home #: (____)_____ **Cell #**: (____)_____ **Alt #**: (____)_____

I hereby give consent to contact the above-named person if I require emergency care / hospitalization.

_____ _____

Patient / Guardian Signature **Date**

BIOLOGICAL PSYCHIATRY CENTER, P.C.
HIPAA Privacy Policy Form

By signing this form, I consent to the use or disclosure of my Protected Health Information by my provider Biological Psychiatry Center (BPC) and its professional, clerical, and billing staff for purposes of treatment, payment and healthcare operations. This is a joint consent form of BPC and its clinical staff.

Protected Heath Information means health information (including identifying information about me) collected from me or received by BPC, another provider, a health plan, my employer or a health care clearinghouse. It may include information about my past, present or future physical or mental health or condition, the provision of my health care and payment for my health services.

BPC agrees to maintain my Protected Health Information in accordance with the practices described in the BPC Privacy Notice. This notice also describes my rights with respect to the use and disclosure of my Protected Health Information.

I acknowledge that I have been given a copy of the BPC Privacy Notice and I have been given an opportunity to review the BPC Privacy Notice prior to signing this consent.

I understand that this information may be needed to:

- Plan my care and treatment
- Communicate among the various health care professionals involved in my care
- Provide information to my health insurance company or plan
- Obtain payment from my health insurance company or plan
- Assess the quality of my care and review the care provided by my Assigned Clinicians and other staff

I also understand that I have the right to revoke this Consent, in writing, at any time, except to the extent that BPC has taken action in reliance upon this Consent.

I, _____, authorize BPC and its professional, clerical, and billing staff members to contact **myself,** at the following numbers, regarding any appointment, medical, and billing issues.

Home #: (_____) _____ **Cell#:** (_____) _____
Work #: (_____) _____ **Alt #:** (_____) _____

Patient / Guardian Signature: _____ **Date:** _____

I, _____, authorize BPC and its professional, clerical, and billing staff members to contact **spouse / relative** regarding any appointment, medical, and billing issues.

Spouse: _____ **Relative:** _____
(Name) (Name & Relationship)

Home #: (_____) _____ **Home #:** (_____) _____
Cell #: (_____) _____ **Cell #:** (_____) _____
Work #: (_____) _____ **Work #:** (_____) _____
Alt #: (_____) _____ **Alt #:** (_____) _____

Patient / Guardian Signature: _____ **Date:** _____

Patient Name: _____ **DOB:**_____

BIOLOGICAL PSYCHIATRY CENTER, P.C.

25869 Kelly Road, Suite A
Roseville, MI 48066
(586) 773-6020

Authorization for BPC to Release Patient Information to Insurance Carrier and/or Primary Care Provider (PCP)

Patient Name: _____ **Birth Date**: _____ **SSN**: _____

Patient Address: _____
(No./Street/Apt.) (City/State/Zip)

- **I authorize BPC to release the following information for the purpose of:**

Billing insurance for services rendered
1. Date of Service 3. Procedure Code 5. Facility Name
2. Diagnosis 4. Provider Name 6. Session Notes

☐ _____
(Insurance Carrier)

_____
(No./Street/Ofc. No.)

_____
(City/State/Zip)

~ I am a Private Pay Patient and have received Fee Schedule. _____ (initials)

Coordinating of Care with Primary Care Physician
1. Date of Service 3. Prognosis 5. Treatment Plan
2. Diagnosis 4. Medications 6. Any Referrals made

☐ _____
(Primary Care Physician / Family Doctor)

_____
(No./Street/Ofc. No.)

_____
(City/State/Zip)

~ I do not want coordination with my PCP or Healthcare provider to occur. _____ (initials)

- **This authorization expires on: _____** (specify expiration date or event)
  (If left blank, this release will remain active for the duration of your treatment at BPC.)

- I understand that can revoke this authorization at any time by submitting a signed letter to: Biological Psychiatry Center, PC, 25869 Kelly Road, Suite A; Roseville, MI 48066. Revocations will not apply to information that has already been released. The authorization will not apply to my insurance company to the extent the law provides my insurer with the right to contest a claim under the policy, or the policy itself.

- I understand that, I as the client/parent/guardian who signed this form, can request to review or copy the information released/disclosed pursuant to this Authorization as allowed in 45 CFR 164.524, the Michigan Mental Health Code, 42 CFR Part 2, and any other applicable laws, rules and regulations.

- I understand that my information may be re-disclosed without my consent where allowed by law. I also understand that any release/disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by Federal Confidentially Laws (P.L. 104-191 (HIPAA), 45 CFR Parts 160 and 164).

- I am giving this consent voluntarily and have been informed of the specific information to be released.

Patient or Parent/Guardian Signature[1]: _____ Date: _____

BPC Person Executing Request: _____ Date: _____

[1] *Parent/guardian* indicates that patient is a minor or under care of legally recognized guardian.

Biological Psychiatry Center, P.C. - Financial Policy

Biological Psychiatry Center, P.C (BPC) financial policy describes the patients and practices financial responsibilities. We are committed to providing our patients with the best possible medical care and also to minimize administrative costs. This policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- BPC participates with numerous insurance companies and will submit a claim for services rendered. It is the patient's responsibility to provide us with current insurance information. Copies of Insurance cards and ID should be emailed to forms@bpcpc.com prior to the scheduled appointment or can be brought with you to your scheduled appointment. In the event that the insurance cannot be verified either prior to or at the time of the appointment, we will ask that services are paid in full at time of visit. If payment cannot be made, we will ask that your appointment be rescheduled.
- If our office does not participate with your insurance, we will file a claim upon request however payment in full is expected at time of service.
- **Our office does not accept any form of Medicaid, whether primary, secondary tertiary, etc**… Patients with Medicaid that choose to be seen in our office acknowledge that they will be responsible for all balances. If you apply for Medicaid while in treatment, you will inform the office so appropriate referrals can be made for your to seek treatment at an in-network office.
- It is the patient's responsibility to pay any deductibles, copayments, or any portion of the charges as specified by your insurance plan including non-covered services at the time of visit. If payment is not made at the time of service, a $10 service charge will be charged to your account.
- Majority of insurance carriers place restrictions that they will not cover individuals' claim that see a therapist and psychiatrist on the same day. If you chose to see a therapist and psychiatrist on the same day, and your insurance carrier denies claims, you will be responsible for payment in full for services rendered.
- It is the patient's responsibility to remember their appointments, reminder emails, texts and calls are a courtesy. If you do not cancel with at least a 24-hour notice with MD/DO or 48 hours with a therapist and/or no show for your scheduled appointment with your psychiatrist, charges will be as follows:

MD/DO	15-minute appointment $50	30-minute appointment $100	45-minute appointment $150
Therapist	1 missed appointment $50	2ND missed appointment $100	3RD + missed appointment – Full Fees

- Our cancelation policy will be strictly enforced. The cancelation/no-show charge cannot be billed to your insurance company. You will be responsible for paying the fee prior to being rescheduled. In addition, **if you miss 2 or more consecutive appointments, you may be discharged from the practice for non-compliance**.
- Completion of Insurance and other paperwork are not a covered benefit under medical Insurance plans. A $25 per page fee will be charged for the completion of paperwork.
- Our office coordinates care with Primary Care Physicians and other healthcare specialists. Please know request for letters not to relating to coordination of care will incur a $25 fee and must be paid when requested.
- Payment for services can be made in person, by phone (586) 773-6020 or online at www.bpcpc.com. Payment methods accepted are cash, check or credit card.
- We will send a maximum of two statements in an attempt to collect any unpaid balances. Finance charges will be added to your account if a balance is 60 days past due. If the account is referred to our collection agency you and your family member will be dismissed from the practice. In the event this action occurs, you will be asked to pay the entire balance in full and any additional costs to the practice incurred from the collection agency before any future appointments can be considered.
- Our staff is happy to help with any insurance questions relating to how a claim was filed, or regarding any additional information needed to process the claim. Specific coverage issues however can only be addressed by the insurance carrier's member services department. (Phone number should be listed on back of your insurance card.)
- The adult accompanying a minor and parents or guardian of minors are responsible for payment at the time of service. For any unaccompanied minors, payment must be made prior to the scheduled appointment unless prior arrangements have been made with the billing department.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the practice. We are here to help you.

BIOLOGICAL PSYCHIATRY CENTER, P.C.

The Patient-Provider Partnership - Specialists Agreement (Patient Copy)

At Biological Psychiatry Center, P.C., we strive to create a welcoming and supportive atmosphere where you feel heard, respected, and comfortable throughout your healthcare experience. We are committed to providing compassionate care in a positive and friendly environment. The health and wellness of our patients is a top concern of this office. Providing the best possible specialty care to every patient is our primary goal. Your care will be coordinated with your Primary Care Physician. Below are some guidelines to make the best of this partnership.

As our patient, your responsibilities are to:

- Promote positive behavior by being respectful and kind to other patients and staff. Any negative behaviors are not acceptable and will be addressed accordingly.
- Prepare for and keep scheduled visits or reschedule visits in advance whenever possible
- Participate, by attending all scheduled appointments and commit to the treatment plan that has been developed for you
- Follow through with recommended testing and contact our office if you are unable to get these tests completed
- Be sure you understand the treatment plan, if not ask questions
- Tell us immediately if you are unable to follow your recommended treatment plan so we can modify it for you to receive the best results possible
- Be honest about your history, symptoms and other important information about your health
- Tell your psychiatrist or therapist any changes in your health and wellbeing
- Follow up with your Primary Care Provider for overall healthcare needs
- Provide us with your e-mail address so we can provide patient education regarding medications and diagnosis through portal

As your provider office, our responsibilities are to:

- Promote positive behavior by being respectful and kind to BPC, PC patients. Any negative behavior will not be tolerated and will be addressed accordingly by administration.
- Schedule your appointment as soon as possible
- Communicate regularly with your Primary Care Provider to make sure we coordinate your care
- Consider all your needs when we work with you to develop a treatment plan related to the reason for your referral
- Provide 24-hour access to medical care and same day appointments, whenever possible.
- Provide instructions on how to meet your health care needs when the office is not open – Urgent Cares listed below
- Provide information to help you learn how to self-manage your condition and assist with establishing goals for this condition.
- Provide you with clear directions about medicines and other treatment options
- When necessary, direct and coordinate your care through referrals to appropriate community resources
- End every visit with clear instructions about your diagnosis, expectations, treatment goals and future plans

Office hours:
Monday - Thursday 8:30am to 7pm / Fri 8:30am to 5pm

Office closed the following Holidays:
New Year's Eve & Day*; Memorial Day; July 4th; Labor Day; Thanksgiving Day & Friday; Christmas Eve & Day*
*Additional days may be affected, please call to verify office hours

For after-hours medical care, please proceed to the following Urgent Care Centers or Emergency Rooms.

URGENT CARE: (Hours: 8am to 8pm Daily)

MyHealth Urgent Care – St. Clair Shores: 25515 Harper, St. Clair Shores, MI 48081 **Phone:** 586-435-0160
MyHealth Urgent Care – Macomb Twp: 18200 23 Mile Road Macomb Twp., MI 48044 **Phone:** 586-992-5500

EMERGENCY ROOMS: (Hours: 24 hours / 7 days per week)

Henry Ford St. John Hospital – Detroit: 22101 Moross Road Detroit, MI 48236 **Phone**: 313-343-3400
Henry Ford St John Hospital – Macomb Twp: 17700 23 mile Road Macomb Twp., MI 48044 **Phone**: 586-416-7500

NEED HELP? 2-1-1 is now available. **Dial 211** from any phone and you will be connected with a referral hotline that can connect you with non-profit agencies in your area that can help with Human, Health and social needs (i.e., utilities, housing, health insurance, food, diapers, etc.) A listing of the area resources can also be found on this website: http://www.referweb.net/uwjc

Thank you - Biological Psychiatry Center, P. C.

Patient Name:_____ **Date Received:**_____ **Parent:**_____