GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC

Patient Information and Contact Agreement

Patient:

Last Name: _____ First name: _____

Date of Birth: _____ Social Security Number: _____

Marital Status: _____ Sex: _____

Address: _____

City, State, Zip Code:_____

Employer: _____

Primary Phone Number: _____ Type: _____

Secondary Phone Number: _____ Type: _____

E-mail: _____

Emergency Contact:

Name: _____

Primary Phone: _____ Type: _____

Secondary Phone: _____Type: _____

E-mail Address: _____

Relationship: _____

Parent / Guardian Information (REQUIRED if patient is under 18 years old):

Last Name: _____

First name: _____

Date of Birth: _____ Social Security Number: _____

Custody Status: *please indicate joint or sole (mother or father or guardian)*

Legal: _____ Physical: _____

Address: _____

City, State, Zip Code:_____

GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC
44031 Pipeline Plaza, Suite 205, Ashburn, VA 20147 Tel 571-291-2449 Fax 571-291-3681

GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC

Patient Information and Contact Agreement

Primary Insurance Information (please provide copy of both sides of current insurance card):
Insurance Company: _____
Group Number: _____
Member ID Number: _____
Effective Dates: From: _____ To: _____

Insured's Information (if not self):
Relationship to patient: _____
Last Name: _____ First name: _____
Date of Birth: _____ Social Security Number: _____
Marital Status: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip Code:

Secondary Insurance Information (If applicable, please provide a copy of both sides of current insurance card):
Insurance Company: _____
Group Number: _____
Member ID Number: _____
Effective Dates: From: _____ To: _____

Insured's Secondary Information (if not self):
Relationship to patient: _____ Employer: _____
Last Name: _____ First name: _____
Date of Birth: _____ Social Security Number: _____
Marital Status: _____ Sex: _____
Address:
City: _____ State: _____ Zip Code: _____

I authorize Gonzales-Vigilar Psychiatric Services to contact me and leave messages for me using any of the above listed contact information.

_____ _____
Patient / Parent / Guardian Date

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GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC

Financial Policies Agreement

Patient Name: _____ Date: _____

I. Insurance

a. If you have medical insurance, please assist us in complying with your insurance requirements. Gonzales-Vigilar Psychiatric Services (GVPS) asks that you update us on changes to your personal and insurance information, and provide us copies of your current insurance card and driver's license. We are required by law to obtain your signature for permission to release information to your insurance carrier. If your provider is in-network with your insurance company, as a courtesy we will file claims with your insurance company for your covered medical services. However, we expect payment of all services rendered within 60 days. It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 60 days. It is your responsibility to understand your coverage and benefits, including pre-certifications, referral and authorization requirements.
X_____ **(initial)**

b. GVPS will file claims with, and attempt to collect from, your insurance company. If the claim is not paid within 60 days, you will be billed for the remaining balance. You agree to waive any insurance company policy rights that would prevent you from being responsible for these unpaid charges.
X_____ **(initial)**

c. If your insurance coverage changes and you do not notify GVPS within 30 days of that change, GVPS reserves the right to NOT issue a refund. You agree to waive any insurance company policy rights that require refund of the aforementioned monies.
X_____ **(initial)**

II. Payment for Services

a. Payment of your deductible, copay, or coinsurance is due at the time services are rendered. Our failure to collect these amounts may be a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts may be a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your employer and/or insurance company representative.
X_____ **(initial)**

b. Returned checks will result in a $50.00 fee being assessed to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised may be subject to external collection and additional collection fees, including attorney and other court fees. If your account has more than one returned check, then you will not be allowed to write checks for future services.
X_____ **(initial)**

c. Your insurance plan is a contract between you and your insurance company. As medical care providers, our relationship is with you, not your insurance company. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.
X_____ **(initial)**

In accordance with the GVPS financial policies above, I hereby understand and agree to the following terms:

GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC
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1. I accept financial responsibility for all clinical and administrative services provided by GVPS.

2. I authorize the release of any medical, mental health, or other information necessary to process a claim with my insurance carrier.

3. I authorize payment to GVPS for all services rendered. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

4. I understand that, due to the nature of my treatment, there may be a need for GVPS to exchange information with other parties, such as other treating physicians *(**NOTE:** If you DO NOT wish to give GVPS permission or have any doubts about granting this permission at this point to exchange information with other physicians, please cross out this paragraph. If you cross out this paragraph, GVPS will ask you to sign separate release of information forms when and where appropriate)*.

5. I understand and agree that certain ancillary services (i.e., services which are not part of an initial assessment nor provided as part of a scheduled appointment) may be performed for me by my provider at GVPS. I understand and agree that these services are not covered by insurance, and that I will pay GVPS the corresponding rates for these services. Examples of ancillary services include but are not limited to: patient related phone calls including phone consultations with patient or family members, physicians, therapists, psychologists, school officials, attorneys; crisis counseling by phone; time associated with preparing for non-appointment medication refills; completion of any forms during non-appointment times, legal and court related matters, etc.

6. I understand and agree that if my account goes to a third party for collections; I am responsible for all fees incurred.

7. I understand and agree that if I have a balance on my account that it needs to be paid before my appointment and that failure to pay the debt may result in me not being seen and a missed appointment fee being added to my account *(**NOTE:** If you are unsure of your balance, please call GVPS).*

I have read, fully understand, and agree to abide by the policies in this agreement.

Patient / Parent / Guardian's Name: _____

Signature: _____ Date: _____

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GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC

Managed Care Waiver
Acknowledgment of Health Insurance Plan Responsibilities

Patient Name: _____ DOB: _____ _ Patient's Health Plan: _____
Subscriber Name: _____ Proposed Service or Treatment:_____ _____

Section I

I understand and agree that I (or the holder of a third party health plan agreement on my behalf) am responsible for knowing my insurance benefits and which providers are eligible to receive payment of the benefits. I assume complete responsibility for payment of all services that are not covered by my insurance benefits or eligibility determination and my applicable co-pay, deductible, and co-insurance for covered services.

Section II

I am enrolled in an **H-M-O insurance** plan that requires a Primary Care Physician (PCP) referral for specialty services. I am choosing to obtain the above services with the specialist without a PCP referral. I understand that I will be Self-Pay and thus, responsible for all charges associated with all services necessary for diagnosis and/or treatment, at time of service. Initial _____

I am enrolled with a **Point-of-Service insurance** plan that allows me to self-refer to a specialist without my PCP referral. I understand that in choosing this option, I may have a higher out-of-pocket cost in accordance with my insurance benefits. Initial _____

I am enrolled with a **Preferred-Provider-Organization insurance** plan that allows me to seek medical services from an out-of-network provider. I understand that in choosing this option, I will be self-pay and thus, fully responsible for all charges associate with this service necessary for the diagnosis and/or treatment. I understand that I am expected to pay at the time of services rendered. I understand that it is my responsibility to submit any necessary information to my insurance plan that may reimburse some portion of the charges in accordance with my insurance benefits. Initial _____

I am electing to see a PCP that I have not selected and is outside of the network of providers. Therefore I am accepting responsibility for all charges associates with services received at time incurred.

I am requesting to receive services that my health insurance plan deems to be non-covered. By signing this waiver, I am agreeing to be responsible for payment in full. Furthermore, I understand that I cannot seek reimbursement from my health insurance plan.

_____ _____
Date Signature of patient or person acting on patient's behalf

_____
Print name of patient or person acting on patient's behalf

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Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice covers all information in our written or electronic records which concerns you, your care and payments for your care. It also covers information we may have shared with other organizations to help us provide your care, get paid for providing your care, or manage some of our administrative operations.

Gonzales-Vigilar Psychiatric Services (GVPS) may use and disclose protected health information (PHI) about an individual for:

a. Mental Health Treatment – i.e.; providing mental health care services, sending/coordinating care information with other health care providers caring for you, ordering and obtaining off site tests/results, writing prescriptions, etc.
b. Payment – i.e.; submitting insurance claims on your behalf for treatment rendered.
c. Health Care Operations – i.e.; internal business planning activities and quality of care evaluation.

GVPS is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization, including, but not limited to:

a. **Disclosures required by law**
b. **Disclosures to avert serious threats to health and safety**
c. **Disclosures with reference to Workers' Compensation or Food and Drug Administration**

Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization. (Please see below for identifying persons to whom you would allow disclosures of otherwise protected information).

GVPS may contact the individual to provide appointment reminders or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. GVPS will routinely contact patients via telephone or secured e-mail at home and/or work and, unless otherwise requested, may leave messages on the appropriate voice mail or answering service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information:

a. The right to request restrictions on certain uses and disclosures of protected health information. However, GVPS is not required to agree to a requested restriction.
b. The right to receive confidential communications of protected health information, as applicable.
c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
d. The right to amend protected health information, as provided in the Privacy Regulation.
e. The right to receive an accounting of disclosures of protected health information.
f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

GVPS is required by law to maintain the privacy of the protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. GVPS is required to abide by the terms of the Notice currently in effect. GVPS reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. GVPS will provide individuals or patients with a revised Notice by posting new regulations in each office.

Individuals may complain to GVPS and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated. GVPS's contact person for matters relating to complaints is:

Greg G. Vigilar, Jr., Ph.D.
24600 Millstream Dr., Suite 340, Stone Ridge, VA 20105

GONZALES-VIGILAR PSYCHIATRIC SERVICES, LLC

Please provide the name(s) of person(s) if any, to whom you would permit GVPS to disclose personal health information as necessary for your continued health care. Please also note if specific health care information cannot be disclosed (i.e.; test results, appointment information, etc.) Otherwise, we will disclose only what is necessary for your continued health care in accordance to the Privacy Policy.

List below those individuals (family, friends, interpreter services, etc.) you will allow disclosure of your personal health information from GVPS as necessary during the course of your health care services:

Name and Relationship	**Allowed Disclosure(s) Please circle ALL or specify**
Name_____	All or Specify: _____
Name _____	All or Specify: _____
Name _____	All or Specify: _____
Name _____	All or Specify: _____
Name _____ _____	All or Specify: _____

_____ (Initial) I acknowledge and understand that GVPS policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment (i.e., my designated primary care provider or physician/dentist seen for consultation/treatment). GVPS policy is to only disclose specific information necessary for coordination of my health care or mental health treatment.

List below physician providers to whom you **DO NOT** want specified private health information sent, even if such information could be sent in the usual course of facilitating or coordinating medical treatment.

DO NOT SEND PHI: Provider Name: _____ All or Specify _____
DO NOT SEND PHI: Provider Name: _____ All or Specify _____

_____ (Initial) I acknowledge and understand GVPS policy to contact me by various means when necessary for my health care services which may include by home/work/cell phone, fax, and/or email. I also understand that private health information may be included in that communication to me.

I have read and understand GVPS Notice of Privacy Practices.

Signature _____ Date _____

Printed Name _____

Patients Name (if under 18) _____

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Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral health care services offered at and provided by Gonzales-Vigilar Psychiatric Services.

I understand that I am consenting and agreeing only to those services that the provider is qualified to provide within: (1) the scope of the provider's license, certification, and training: or (2) the scope of the license, certification and training of the behavioral health care provider directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent to treatment, and I am legally authorized to initiate and consent to treatment on behalf of this individual.

Patient / Parent / Guardian's Name: _____ Signature: _____

Policy on Medication Management Follow-up Appointments

It is very important that you follow your physicians' treatment guidelines. At each appointment, your doctor will indicate a time frame for your next visit. It is your responsibility to ensure that you have follow-up appointments scheduled within the time frame indicated by your physician, and that you keep these appointments. **Please note that your physician cannot refill medications without performing the appropriate follow-up evaluation.**

Some appointment times fill up very quickly. We strongly recommend that you schedule your next appointment before you leave the office. If that is not possible, please do your best to schedule follow-up appointments shortly thereafter. This will allow you to choose a time that suits you, and will ensure that you do not run out of medication, as it can be sometimes dangerous to abruptly stop your medication. Delays in scheduling follow-up appointments may result in significantly limiting your appointment time options.

I have read, understand, and will abide by the above policy:

Patient / Parent / Guardian's Name: _____

Signature: _____ Date: _____

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Cancellation Policy Agreement

PLEASE NOTE: All patients must read, sign, and agree to the cancellation policy prior to their first scheduled appointment. Failure to do so may result in denial of services by Gonzales-Vigilar Psychiatric Services (GVPS).

I understand and agree that GVPS has reserved the time for my appointment exclusively for me, and that my missing the appointment, or untimely cancellation of the appointment on my part, makes it difficult to schedule other patients in my place.
Should I intend to cancel my scheduled appointment, I understand and agree to notify GVPS of such intent at least 24 hours prior to the start of the appointment. I understand and agree that I must make the aforementioned timely cancellation by speaking with a GVPS representative, leaving a voicemail message, or sending a text or email message to GVPS.
I understand and agree that I will be charged a $100 fee if I miss an appointment without making a timely cancellation. I understand and agree that failure to pay the aforementioned missed appointment fee may result in the denial of further services by GVPS.

I understand and agree that I may cancel an appointment with less than the required timely notice ***ONLY*** in the following situations:

- **a.** Loudoun County Government (***NOT*** the Loudoun County School System) is declared closed due to snow or inclement weather, or
- **b.** I am ill. In this event, I agree to provide GVPS a note from the medical professional or hospital indicating the date and time I was examined.

In either case, I must notify GVPS by speaking with a GVPS representative, leaving a voicemail, text, or sending a text or email message, prior to my appointment.
I understand and agree that I may appeal in writing to GVPS to waive a missed appointment fee. I understand and agree that I will pay the fee prior to sending a written appeal, submit the appeal within 30 days of the missed appointment, and accept GVPS' appeal decision as final.

I have read, fully understand, and will abide by the terms of this Cancellation Policy Agreement.

Patient Name: _____

Parent or Guardian Name: _____ (if patient is under 18)

Signature: _____ Date: _____

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Policy on Rights of Separated or Divorced Parents/Guardians to Consent to Mental Health Services for Minor Child

In the event of a divorce or separation, the Commonwealth of Virginian recognizes only two legal custodial rights for parents/guardians of minor children: **1) Sole Custody** or **2) Joint Custody**. No other physical custody arrangements are legally recognized within the State.The right of a parent/guardian of a minor child to seek mental health services for the minor child varies by the parent/guardian's legal custodial designation as follows:

1) **SOLE LEGAL CUSTODY:**
   A parent/guardian with **sole legal custody** has the right to seek a mental health evaluation and/or treatment of a minor child unilaterally and without consent from the non-custodial parent.

2) **JOINT LEGAL CUSTODY:**
   A parent/guardian with **joint legal custody** will be required to produce appropriate documentation in order to determine:
   a. Whether the other parent/guardian must be notified in the event one parent seeks mental health services for the minor child; **AND/OR**
   b. Whether both parents/guardians must agree to obtain a mental health evaluation and/or treatment for the minor child.
   c. *PLEASE NOTE: In some cases, depending on the custody agreement, parents/guardians who disagree can have a judge determine whether mental health services are in the minor child's best interest.*

3) **NO LEGAL CUSTODY:**
   A parent/guardian **without** a recognized legal custodial right:
   a. Has the right to access the minor child's medical records;
   b. Can seek emergency medical treatment, which likely will not include mental health treatment; **AND**
   c. Can petition a court for an order prohibiting the evaluation and/or treatment of the minor child because it's not in the child's interests.

In accordance with these limitations, GVPS has enacted the following policies for separated or divorced parents/guardians of minor children seeking mental health services for the minor child:

1) A parent/guardian with **sole legal custody** shall produce, prior to services:
   a. A <u>letter</u> from his/her attorney stating that there is nothing in the custody agreement that would prevent this individual from seeking evaluation and/or treatment of this child; **OR**
   b. <u>Evidence</u> in the form of a copy of the section of the court approved legal custody agreement verifying that parent/guardian is the sole legal custodian and has the unilateral right to make decisions with regard to the minor child's mental health.

2) A parent/guardian with **joint legal custody** shall produce prior to services:
   a. <u>Evidence</u> of the court-ordered joint legal custody agreement (see above); **AND**
   b. <u>Written consent</u> from both parents to pursue mental health services for the minor child.

As the parent/guardian of _____, I, _____, acknowledge the GVPS Policy on consent for mental health services for a minor by separated or divorced parents, and agree to furnish the appropriate documents, as described herein, to prove my custodial right to seek said mental health services.

_____	_____	_____
Printed Name	Signature	Date

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CONSENT TO TREAT MINOR PATIENT WITHOUT PARENT PRESENT

The State of Virginia and the Virginia Medical Board require consent before medical care can be given. In order for us to treat a minor without his or her parent/legal guardian present (i.e. for clinicians to speak to a child without his or her parent/legal guardian actually in the clinician's office), the parent/legal guardian should complete this form and return it to Gonzales-Vigilar Psychiatric Services (GVPS).

I, _____ (print parent/legal guardian's name), am the parent/legal guardian of _____ (print patient's name), currently a minor, whose date of birth is _____.

I authorize GVPS to provide mental health care to my son/daughter, including but not limited to, diagnostic and necessary medical treatment as deemed appropriate by his/her physician or clinician.

I understand that, should my minor child need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such are is initiated.

I further understand, once my child reaches the age of majority, my consent for treatment is no longer required. This consent will remain in effect until the patient reaches the age of 18, unless revoked in writing to GVPS.

By signing this, I acknowledge that I have head and agreed to this consent and that any questions I had prior to signing were answered by GVPS.

Patient's Name: _____

Parent/Legal Guardian's Name: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Emergency Contact

Name: _____

Relationship to Patient: _____

Home: _____

Cell: _____

Work: _____

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