WELCOME TO OUR PRACTICE!

At Hagan Health we are dedicated to giving you courteous, caring, treatment. Included in this packet you will find valuable information on the policies and procedures of our office. Please read each page carefully, as it will help us serve you more efficiently and completely. Any pages requiring your initials, signature, or answers to questions, you should fill out as completely as possible and bring with you to your first appointment. It is strongly recommended that you keep a copy of our payment schedule and policies and procedures for reference should you have questions in the future. Thank you, and again, welcome to our practice!

Our secretarial office hours are as follows:

Monday – Thursday: 8:00 am to 6:00 pm
Friday: 8:00 am to Noon

Payments:

- We accept checks, cash, debit or credit cards.
- Please be prepared to make payment at the time of service.
- If you have any questions, please call our office at: (502)326-3011
- Please bring the completed forms & payment with you to your initial evaluation.

If you are using insurance, it is your responsibility to contact your insurance company to determine benefits and how much, if anything you are responsible to pay for your visit. (co-pay, etc.) **Initial: __________

You will not be seen if you fail to bring these completed forms and your payment to your initial evaluation.

Hagan Health | 4010 Dupont Circle, Suite 202 | Louisville, KY 40207
Phone: (502)326-3011 Fax: (502)324-4577
www.haganhealth.com

Patient Information Form

Statistical

Name: ___________________________________ Birthday:___/___/___ Sex:______________

Address: ____

City: ______________________________ State: ___________________ Zip: _______________

Main Phone:________________ Cell:_______________ Email:_________________________

Occupation: ______________________________________ SSN: ________________________

Employer: ____

Parent's Name (If the patient is a minor):____

____

____

____

Please list all legal guardians (If the patient is a minor):____________________________

____

____

____

Marital Status: Married Single Widowed Divorced

Spouse's Name_______________________________

May we call you at work, in case of schedule changes?__________________________

Emergency Contact

Name: ____

Phone: ____

Relationship to You: ____

Insurance & Employee Assistance Program Information

Insurance Co:____ Phone: (____)_____-_______

Policy Holder:____ SSN: _____-____-_______

Relationship:____________________________________ Effective Date: ____/_____/______

Policy #: _______________________________ Group#: _____________________________

Subscriber DOB**___________________

Pharmacy Information

Pharmacy Name: ______________________________ Phone: (____)______-____________

Pharmacy Address or intersection:____

Drug Allergies:____

Name:____ Date:____/____/_______

PSYCHIATRIC HISTORY

Have you seen a psychiatrist in the past?______ Who?__________ When?________

Did you receive a diagnosis?____

Have you ever taken any medication for psychiatric treatment?: YES_____ NO_____

Please list all psychiatric medications you have been on in the past:

____

Are you taking any medications currently?: YES_____ NO______

If yes, list here:____

Do you have a history of Inpatient psychiatric treatment? YES_____ NO______

If yes, where? _________________________Date(s)_________

Tell me about any alcohol use currently.__________________________________

Tell me about any recreational drug use currently.___________________________

Have you used excessively in the past?____________________________________

How much caffeine do you consume? Mild Moderate Excessive

Have you had any talk therapy or counseling recently?________________________

Or in the past?____

Have you felt bad enough that thoughts of ending your life have gone through your head

currently? ____

In the past?____

Thoughts of ending anyone else's life? ___________________________________

In the past? _____________________________________

Have you ever tried to harm or kill yourself? YES_____ NO_______

(If NO, skip to the next section)

Was it your intent to die? YES_______ NO__________

Elaborate, if desired:____

When was the most recent incident? ____________________________________

SOCIAL HISTORY

Do you currently live in a home you own?__________ Do you rent? ____________

Have you been married? _______How long?_______

Do you have children?______ Ages?____________

Have you ever been in trouble with the law? _______________________________

Have you served in the military? _____________________________________

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What is your religious and spiritual history? ____________________________________
Do you have spiritual concerns that you would like to discuss? _____________________

PAST MEDICAL HISTORY
Do you have any known allergies?____
Please list any current illnesses:____
Please list any major surgery:____
Please list any major injuries:____
Have you had a head injury? YES______ NO_______ When?:_____________________
Who is your Primary Care Physician?____

FOR WOMEN
Are you pregnant?__________________________
Could you become pregnant? _________________
Please initial here that you are aware that psychiatric medications can cause birth defects, and if appropriate, that you will be particularly faithful about using birth control while on psychiatric medications, and that if you were to become pregnant unintentionally, that you will discuss coming off medications with me immediately: ___________

DEVELOPMENTAL HISTORY
Did you have any major childhood illnesses?____________________________________
Were you in regular classes in school?____
Were there any learning problems? ____
Was there any question of ADD?____
What is your level of education? ____
Were you ever emotionally, physically or sexually abused? ________________________

FAMILY PSYCHIATRIC HISTORY (All of your blood relatives.) (Cousins do not count):
Who in your family has been diagnosed and treated for:
Anxiety? ____
Depression?____
Bipolar disorder?____
Schizophrenia? ____
ADHD?____
Other? ____
Has anyone in your family had a problem with alcohol or drugs?
Drug problem?____
Alcohol problem?____

FAMILY DYNAMICS

Were your parents married?______________

Did they have a good marriage?___________

What age were you if and when they divorced?____________________

Would you say that you grew up in a nurturing environment?_________

With how many brothers and sisters did you grow up? ______________

Permission To Share Information

I give permission for Haganhealth to discuss, in general terms, my diagnosis and treatment with the following people:

Therapist or Family Physician (permission to communicate with physician and/or therapist regarding your treatment)

Name: ____

Phone: ______________________ Fax: ______________________

Address: ____

City: ______________________ State: __________ Zip: __________

Family Member(s) (permission to communicate with the following family member(s)

Name: ____

Relationship: ______________________________________

Name: ____

Relationship: ______________________________________

Other (special requests, such as medical records be sent to someone other than PCP)

Specific Request: ___________________________________

To:____

Address:____

Phone: ______________________Fax: ______________________

Patient's Signature: ______________________________________

Witness: __________________________ Date: ________________

I do not give permission for Haganhealth to discuss my diagnosis and treatment

PATIENT POLICIES & PROCEDURES

Insurance Policies

You are responsible for contacting your insurance company ***before*** the scheduled appointment to find out if you need a pre-authorization to some of our providers.

If your insurance company requires pre-authorization for office visits, you are responsible for obtaining that authorization and maintaining follow-up authorizations. Usually you will be given a confirmation number, which you then need to give to us for use when we file your claim. If authorization is needed and you do not obtain it, you could be responsible for the complete cost of care.

Payment confirmed with the insurance company is due in full at the time of service with no exceptions.

Not every provider in our office is in-network with every insurance. It is extremely important to keep the front office updated of current insurances so that you can be notified immediately if your provider does not take your insurance.

Initial: _________

Prescription Policies

Requesting a medication refill is required at least 5 days prior to running out of medications. Under NO circumstances will medications be refilled after hours, on weekends, or on holidays.

To submit a medication refill request go to our website, www.haganhealth.com, click on Form, click on Refill Request, fill out form and press submit. Please make every effort to manage your prescriptions at the time of your visit. Please do not contact your pharmacy with medication refill requests.

Controlled substance medications require an appointment with the doctor every 3-6 months. They cannot be phoned into your pharmacy.

Medications will only be refilled for current patients who maintain their regularly scheduled appointments and have account balances in good standing.

Only prescribers can make changes and answer questions regarding medications. Staff and therapists are unable to change prescriptions or provide any medication-related information.

Initial: _________

Patient's signature indicates you understand the above policies.

Signature: ____ Date: ______________________

Signature of parent or guardian if patient is a minor: _____________________________________

HAGAN Health

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No-Show Policy

I understand that the following represents Hagan Health's charges for missing an appointment or for late cancellations, and that these charges are not billable to insurance resulting in an out-of-pocket rate.

Late cancellations or missed appointments (**Psychiatry**)

- Missing an appointment will result in a **$50 Self-Pay fee**
- Appointment cancellations within **24** hours of the scheduled appointment time will result in a **$50 Self-Pay balance**

Initial: _____

Late cancellations or missed appointments (**Psychotherapy**)

- Missing an appointment will result in a **$75 Self-Pay fee**
- Appointment cancellations within **24** hours of the scheduled appointment time will result in a **$75 Self-Pay balance**

Initial: _____

******When you make an appointment you are "renting" a time slot. The rent is due whether you keep the appointment or not unless the appointment is canceled 24 hours in advance of your scheduled time.***

- **NO EXCEPTIONS** are made for illness or other special circumstances.
- We offer telehealth services as well if you are unable to make it in the office for your appointment (this will need to be communicated with us in advance)
- Payment for any No-Show/Late Cancellation balance is due at the time of your next appointment
- Providers are **unable** to waive No Show Fees
- After a total of 3 late cancellations or 2 No-Shows in a 3 month period Hagan Health has the right to discharge you from the practice

If you are calling during a time period when our office is closed please leave us a voicemail.

I understand that I am responsible for all charges that may be incurred with late canceling or missing an appointment.

Signature: ______________________________________ Date: ____________________

Signature of parent or guardian if patient is a minor: _______________________________

STATEMENT OF CHARGES

I understand that the following represents Haganhealth''s charges for outpatient mental health care.

Sessions with the Physician

Initial psychiatric evaluation: $225

Medication Management visit: Simple, $75

Medication Management: Complex or with Psychotherapy, $105

Psychotherapy w/ Dr. Hagan: 60 minutes, $250

Missed appointments or late cancellations (cancellation within **24** hours of appointment): $50 per event (Not billable to insurance)

Initial: _____

Psychotherapy

60-minute sessions with Vern Rickert, Colleen Kidd, Sheana Pryor, and Suzanne Mesa-Lancaster: $135

60-minute sessions with Ervina Desaussure, Sarah Akers, and Sara Hof: $100

*only therapy interns are able to provide sliding scale fees at this time

Missed appointment or late cancellations (cancellation within **24** hours of appointment): $75 per event (Not billable to insurance)

Initial: _____

Administrative Fees

Urine drug screen: $25

Appointment for paperwork: $65

Initial: _____

ALL PAYMENTS MUST BE MADE AT TIME OF SERVICE. We accept cash, credit card or check. We will give you an invoice upon request to use for reimbursement from your health savings account.

I understand that if I choose to use insurance, I will be required to assign the insurance benefits to Hagan Health. I understand that I am responsible for any deductible or copayment at the time of service. I further understand that if the office is unable to collect from my insurance company after reasonable efforts are made for any services performed, I will owe the remaining balance and will be responsible to contact my insurance company for any further negotiation or reimbursement. If a balance remains unpaid this may result in the postponement of all future appointments until the balance has been paid in full.

______________________________	________________	______________________________
Patient Signature	**Date**	**If Minor - Parent/Guardian**

Requirements to Engage in Telehealth Services

Psychiatry utilizes a platform called DoxyMe. The morning of your appointment, you will be sent a link to your provider's virtual waiting room. If you do not receive a link, please be sure to check your spam folder. If your link is not in your spam folder, please contact the front desk.

Psychotherapy utilizes Zoom. You will receive a link to your Zoom session via email. If you do not receive a link, please be sure to check your spam folder. If your link is not in your spam folder, please contact the front desk.

Once the front office staff informs the provider that you are ready, your provider will begin your session.

At the time of your session you need to be stationary in a quiet and private place.

- You CANNOT be driving, running errands, or in a public space during your appointment.
- You need to be in a separate room or space where others will not interrupt your session.
- This is both to maintain your privacy and to ensure you can hear your provider and your provider can hear you.
- If these conditions are not met, your provider reserves the right to ask you to reschedule and you may be charged a no-show fee.

Standard no-show policies and no-show fees apply to telehealth sessions. Payment for fees or services are due at the time of your appointment. We do not carry over balances. Any cancellations or need to reschedule should be communicated to the office 24 hours in advance whenever possible.

The front office staff and your provider cannot provide technical support for telehealth platforms, so it is recommended that you try logging in before your session to make sure everything is working correctly.
Initial_______

Hagan Health has a strong telehealth platform and failure to connect will always be due to a weak connection on the patient's end. This failure to connect is subject to a no-show fee. Visit our Statement of Charges and No Show policy for more information.

Patient's signature indicates you understand the above policies.

Signature: ____ Date: ________________________

Signature of parent or guardian if patient is a minor: _______________________________________

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such *Notice of Privacy Practices* prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the *Notices of Privacy Practices*.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

______________________________	______________________________
Patient's Name	DOB: (mm/dd/yy)
______________________________	______________________________
Signed (Patient or Legal Representative for Patient)	Date:
______________________________	(Legal Representative's Relationship to Patient)

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