Welcome to our practice!

Because you are a new patient, we *do* need some paperwork filled out.
I've attached our Registration Packet, you can:
-Print it out and fax it back
-Scan and email it back
-Or even snap a picture of each once they're filled out and email them from your phone.
We will make that work!

We will also need a picture of your Driver's License, as well as the front-and-back of your insurance card, which can be sent the same ways.

Patient Information

Patient Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Male ☐ Female ☐ Soc. Sec# _____

Home #: _____ Cell #: _____ Email: _____

Marrital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Emergency Contact: _____
Name Phone Relation

Patient's Employer or School: _____

If a minor: Mother's Name: _____ Father's Name: _____

Mother's Phone #: _____ Father's Phone #: _____

(If a minor, responsible party must be parent initiating treatment.)

Responsible Party's Name: _____ Phone: _____

Address: _____

Responsible Party's Employer: _____

Spouse's Name: _____ Spouse's Employer _____

Family Physician: _____ Address: _____

Current Medications: _____

Current Pharmacy: _____
Pharmacy Phone Number

Drug Allergies: _____

Current Health Problems: _____

Insurance Information

Primary Coverage: Insurance Company: _____

Subscriber's Name: _____ Soc.Sec #: _____

ID#: _____ Group #: _____

Secondary Coverage: Insurance Company: _____

Subscriber's Name: _____ Soc.Sec #: _____

ID#: _____ Group #: _____

Assignment of Benefits, consent to release information and permission to treat self or minor patient:

I hereby assign any medical benefits from my insurance to Rodney E. Vivian, M.D., Inc this assignement will remain in effect until revoked by me in writing. I understand that I have the ultimate responsibility for all charges. I hereby consent said asignee to release all information necessary to secure payment, including but not limited to, information required by insurance. My permission is given to exchange information with the patient's primary care physician. I allow treatment of myself, or if the patient is a minor, I allow treatment of said minor in my role as parent and/or guardian.

Signed: _____ Date: _____

RODNEY E. VIVIAN, M.D. INC.& ASSOCIATES

OFFICE POLICY

PAYMENT FOR PROFESSIONAL SERVICES:
The fee for professional services is the patient's responsibility, or if the patient is a minor, the fee is the responsibility of the parent/guardian who initiates treatment. However, we will file insurance form and do-what we can do facilitate the payment of fees by your insurance carrier.
REMINDER INSURANCE INFORMATION MUST BE KEPT CURRENT AND ACCURATE. It is the patient's responsibility to contact insurance to verify your therapist is on the panel of your particular policy and to obtain an initial authorization for treatment if required. Failure to do so may result in insurance denial, which means you will be responsible for all charges

CO-PAYMENTS:
For your insurance contracts with a set copayment; that co-pay is due at the time of service. **If the co-pay is not paid at the time of service, there will be a $10 fee added onto your co-pay amount. If you fail to provide proof of insurance there will be a $65 charge at the time of service.** We require that you pay and balance due on your account within 30 days of the insurance payment their portion. Self-pay patients must pay in full at the time of service. Failure to pay in full your portion of the balance may result in termination of treatment and possible collection action.

PSYCHOLOGICAL TESTING:
Psychological testing may be recommended as a part of your treatment. Your insurance carrier may or may not reimburse for the service depending on policy provisions. If they do not reimburse for this service, you will be responsible for the fees unless the denial was due to failure to obtain authorization.

TREATMENT SUMMARIES/REPORTS:
Treatment summaries to referral sources or to facilitate transfer of care are completed at no charge. A fee may be charged for special reports, completion of certain medical forms, copies of records for patient use, phone consultations with collateral sources, etc. Please discuss these fees with your therapist. **NO REPORTS OR RECORDS WILL BE RELEASED IF AN ACCOUNT IS DELINQUENT.**

TERMINATION OF TREAMENT:
Cancellation of appointments without rescheduling or lack of as least one monthly appointment (unless otherwise directed by the therapist) will constitute termination of the therapeutic relationship. **YOU MUST BE IN ONGOING THERAPY FOR MEDICATIONS TO BE CONTINUED, UNLESS YOU HAVE BEEN DISCHARGED BY YOUR THERAPIST.**

PRIVACY PRACTICES:
Our office privacy practices are posted in our waiting room and a copy is available to you upon request.

MEDICATION APPOINTMENT WITH MINORS:
Any minor who has an appointment with Dr. Vivian **MUST** be accompanied by a parent or guardian or patient will not be seen.

RANDOM DRUG SCREENING:
For any patients that are prescribed controlled substances, you may be subjected to random drug screening. There will be a charge for these services that the lab will bill your insurance carrier for.

Signature:_____ Date:_____

RODNEY E. VIVIAN, M.D. INC. & ASSOCIATES

CANCELLATION AND FAILED APPOINTMENT POLICY

In a psychiatric office, all appointments constitute a significant amount of time. If you need to cancel an appointment, please do so **at least** 24 hours in advance so that other patients may utilize the time. You will be charged for failing to keep an appointment, or for cancellation of an appointment with less than 24 hours notice **regardless of the reason** for cancellation. **This fee cannot be billed to your insurance,** and if left unpaid, will be reported to our collection agency.

This charge must be paid before your next appointment.

If you have any questions about this policy, please feel free to talk with your therapist. The clerical staff **cannot** remove broken appointment charges. This is the exclusive prerogative of your clinician.

Signature:_____ Date:_____

Credit Card Charge Authorization
(optional)

I, cardholder _____

Authorize to charge my credit card in the amount of $_____

For (Description of service) _____

Card (please check one)

☐ Discover
☐ MasterCard
☐ Visa

Credit Card Number _____

Expiration Date _____CVV_____ Billing zip code_____

I give consent for this Credit Card to be used for today's services.

I have read, understood, and agreed with the terms listed above.

Signature: _____ Date:_____

I give consent for this Credit Card to be used for any future services.

Signature: _____ Date: _____

Rodney E. Vivian, M.D., INC & Associates
8000 Five Mile Road Ste 240
Cincinnati, OH 45230
PHONE: (513) 232-3070

FAX: (513) 232-5794

HIPAA Authorization

We are required by law to maintain the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. seq., and regulations promulgated there under, as amended from time to time (collectively referred to as "HIPAA").

By signing this authorization, you acknowledge that you have been provided a copy of and have read and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA.

By signing this authorization, you agree that Rodney E. Vivian, M.D., INC & Associates may disclose your personal health care information to:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Print Name: _____

Signature: _____

Address: _____

_____

_____

Date _____

RODNEY E. VIVIAN, M.D & ASSOCIATES
8000 Five Mile Rd., Suite 240
Cincinnati, Ohio 45230
Phone:(513)232-3070 Fax: (513)232-5794

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ D.O.B:_____

I hereby authorize Rodney E. Vivian, M.D. and Associates;

TO (check which applies)
_____ Disclose copies of my records to: _____ Receive copies of my records from:
_____ or exchange my medical information with:

Specific person or Entity:_____ Phone #: _____

Fax #: _____

Full Address/City/State/Zip:_____

I authorize the following information to be released:
___ Full Record (checking this includes release of ALL documents in your clinical record)
___ Other (be specific):_____
This authorization includes but is not limited to records relating to; Diagnosis and/or treatment for alcohol and/or drug abuse/related conditions, AIDS/HIV test results, HIV/AIDS/AIDS Related Complex (ARC) diagnosis and/or treatment, Diagnoses and/or treatment relating to other communicable diseases and/or sexual abuse.

Information requested for time period of FROM (date) _____ TO (date) _____

This authorization for use/disclosure is for the following purpose:
1.____ To coordinate treatment 2.____ to gather assessment information for treatment plan
3. ____ to gather information for ongoing treatment 4. ____ at request of client
5. ____ Other purposes (specify): _____

This authorization will remain effective for (check one of the options below):
____ One-time releases will expire in 180 days unless earlier date is specified here_____
____ All other releases will expire upon case closure.

My refusal to sign this authorization will NOT affect my ability to obtain treatment, payment, or enrollment in a health plan. I understand that I have the right to shorten or lengthen the authorization period at any time, which will require a new release be written. I also understand that I have the right to revoke this authorization, in writing, at any time. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

_____ _____
(Signature of Client/Parent/Guardian – circle one) (Date)

RODNEY E. VIVIAN, M.D., INC. & ASSOCIATES

Child, Adolescent , Adult, Family Psychiatric Practice

8000 Five Mile Road
Suite 240
Cincinnati, Ohio 45230
(513) 232-3070
Fax (513) 232-5794

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William M. Wing, Ed.D.
Daniel Watson, LISW
Michael Madigan, LISW
Roxanne Huston, MSN, CNS-BC
Linda Pettit, MSN, CNS-BC
Carol Dewald, MSN, CNS-BC
LeeAnn Barkman, LISW-S
Bree A. McCabe, LPCC

I have been informed that this office does not accept Medicaid as either primary or secondary insurance.

I am aware that I will be responsible for any balance on my statement of accounts.

Patient Name:_____ Date:_____

Patient Signature: _____

INFORMED CONSENT CHECKLIST FOR TELEPSYCHOLOGICAL SERVICES

Prior to starting video-conferencing services, we discussed and agreed to the following:

- There are potential benefits and risks of video-conferencing (e.g. limits to patient confidentiality) that differ from in-person sessions.
- Confidentiality still applies for telepsychology services, and nobody will record the session without the permission from the others person(s).
- We agree to use the video-conferencing platform selected for our virtual sessions, and the psychologist will explain how to use it.
- You need to use a webcam or smartphone during the session.
- It is important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session.
- It is important to use a secure internet connection rather than public/free Wi-Fi.
- It is important to be on time. If you need to cancel or change your tele-appointment, you must notify the psychologist in advance by phone or email.
- We need a back-up plan (e.g., phone number where you can be reached) to restart the session or to reschedule it, in the event of technical problems.
- We need a safety plan that includes at least one emergency contact and the closest ER to your location, in the event of a crisis situation.
- If you are not an adult, we need the permission of your parent or legal guardian (and their contact information) for you to participate in telepsychology sessions.
- You should confirm with your insurance company that the video sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment.
- As your psychologist, I may determine that due to certain circumstances, telepsychology is no longer appropriate and that we should resume our sessions in-person.

Psychologist Name / Signature:

Patient Name:

Signature of Patient/Patient's Legal Representative:

Date: