

## **New Patient Instructions**

Your appointment has been scheduled with

\_\_\_\_\_ on \_\_\_\_\_ at \_\_\_\_\_

You should arrive to your appointment 10-15 minutes early.

Make sure you fill out this enrollment packet completely.

Bring your insurance ID, photo ID, and any applicable payment with this enrollment packet.

Since we are blocking 1 hour of the physicians time to spend with you it is important that you keep your appointment. If you cannot keep your appointment call us at least 24 hours prior to your appointment.

If your appointment is not kept and not cancelled we reserve the right to ask for a deposit fee by credit card to schedule and secure your next appointment. This amount will be credited to you account at your scheduled appointment. If that scheduled appointment is not kept and not cancelled you will forfeit your deposit.

You may reach our office at 816-453-6777 at any time prior to your appointment with any questions you may have.

Thank you for choosing Northland Psychiatric Specialists, LLC for all your psychiatric needs.

# NORTHLAND PSYCHIATRIC SPECIALISTS, LLC

## PATIENT PROCEDURES AND FINANCIAL POLICIES

The office is open Monday through Thursday. The phone number is 816-453-6777. Our phones are answered between 8:00 am and 5:00 pm with the exception of 12:00 and 1:00 daily for lunch.

When calling after office hours you will have the option to speak to a psychiatrist in an urgent crisis only.

The physicians of Northland Psychiatric Specialists, LLC require that all "treatment questions" be limited to discussion during your appointment. If necessary, our medical assistant can address these issues at other times. It is advisable to document information needed to speak to the physician about and bring this documentation with you to your next scheduled appointment.

**Refills** are done during office hours only and do not constitute an emergency or crisis situation. The office requires 72 hour notice to refill your prescription. You must call your pharmacy for the refill, they will in turn contact us with the necessary information to refill your medication. Some prescriptions cannot be called into the pharmacy, faxed, or mailed; these must be picked up in the office between 8:00 am and 12:00 pm or 1:00 pm and 5:00 pm with proper photo identification only.

**Mail order** pharmacy usage cannot start until a new prescription is needed. The office does not cancel prescriptions with pharmacies. You will need to advise your physician at your next appointment that you wish to use your mail order pharmacy.

**Duplicate prescriptions**, if approved by your physician, you may have an additional fee, this will not be billed to your insurance carrier and must be paid for prior to receiving the prescription.

**Physician/patient phone calls** are limited and are subject to additional charges not billable to your insurance carrier. Excessive and/or time intensive physician/patient calls will be billed a fee subject to the physician's discretion.

**Medical Records and Forms**, (Disability, FMLA, Return to work) are subject to additional processing fees. These fees range from \$20.00 to \$300.00 and are due prior to receiving your paperwork. A minimum of 14 days to a maximum of 30 days for completion is required.

**Appointment Cancellations** require 24 hour advance notice. No cancellation or late (less than 24 hour notice) cancellation will be charged \$35.00, \$65.00 or \$90.00, which will need to be paid prior to your next appointment and may result in a "failure to comply" discharge from our practice.

**Reminder calls** are a courtesy service and should not be depended upon.

**Physician cancellations** are sometimes necessary. We apologize for any inconvenience this may cause.

**Copayments, deductibles and coinsurances** are due at the time of service. These are estimates only and cannot be considered full payment. Any balance due after the insurance processes the claim will be billed to you and is due and payable upon receipt of invoice.

**Minors** will not be given any prescriptions refills or medication changes without the consent of a parent or legal guardian.

**Return checks** are subject to a \$35.00 fee in addition to the amount of the check and may be subject to prosecution under the guidelines of the law with the Clay County Attorney's office.

**Resubmission of claims** due to incorrect insurance information may be subject to a \$35.00 reprocessing fee. It is the patient/parent/legal guardian responsibility to make sure we have the most up to date insurance information.

**Collection agency placement** will be subject to a \$50.00 assignment fee as well as the balance on your account.

**PROFANITY AND RUDENESS WILL NOT BE TOLERATED AND MAY RESULT IN DISCHARGE OF CARE.**

**NORTHLAND PSYCHIATRIC SPECIALISTS, LLC reserves the right to discharge any patient from our practice at any time for failure to comply with treatment recommendations, failure to follow office procedure and policies, and/or failure to meet your financial obligations/placement with our collection agency.**

# Northland Psychiatric Specialists, LLC

**Date:** \_\_\_\_\_ Home phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
**Patient Name: Last** \_\_\_\_\_ **First** \_\_\_\_\_ **MI** \_\_\_\_\_ **AKA:** \_\_\_\_\_  
**REFERRING PHYSICIAN:** \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_  
Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Mailing Address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Occupation: \_\_\_\_\_

**Parent Guardian Spouse** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Sex: M \_\_\_\_\_ F \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Street Address: (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**In case of emergency contact:**  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_

**Preferred Pharmacy:**  
Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Is this a mail order pharmacy?** Yes \_\_\_\_\_ No \_\_\_\_\_

**Primary Insurance:**  
Name: \_\_\_\_\_  
Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Secondary Insurance:**  
Name: \_\_\_\_\_  
Identification #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone #: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Social Security #: \_\_\_\_\_ Employer Name: \_\_\_\_\_

**Appointment Reminders and Message Phone:**  
Phone # to call to remind you of your appointment: \_\_\_\_\_  
Phone # to call to leave message: \_\_\_\_\_  
**You may leave a (please choose) Brief \_\_\_\_\_ Detailed \_\_\_\_\_ message at this number.**  
**A brief message will not include any identifying information.**  
**REASON FOR APPOINTMENT:** \_\_\_\_\_

# NORTHLAND PSYCHIATRIC SPECIALISTS, LLC

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Todd P. Hill, D.O.  
Daniel V. Spurlock, D.O.  
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Phone: 816-453-6777 Fax: 816-454-3601

## AUTHORIZATION TO RELEASE CONFIDENTIAL HEALTHCARE INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Also known as: \_\_\_\_\_ Phone #: \_\_\_\_\_

Social Security #: \_\_\_\_\_

I authorize Northland Psychiatric Specialists, LLC to release confidential information regarding my treatment to: (family members or other persons)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I also authorize Northland P Psychiatric Specialists, LLC to release confidential information regarding my treatment to: (Primary Care Physician and/or therapist/counselor)

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

\_\_\_\_\_ **I DO NOT AUTHORIZE** Northland Psychiatric Specialist to release confidential health information to anyone other than myself. I do understand that this information may be needed by other healthcare providers to receive comprehensive and quality healthcare.

This information includes but is not limited to appointment information, billing information and medication information.

I understand that by signing this form I am allowing Northland Psychiatric Specialists, L.L.C. to receive and review confidential health information. I understand that this consent is voluntary and is subject to revocation at any time, except after the information has already been received and may only be revoked by signature.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **NOTICE OF REVOCATION.....THIS REVOCATION CANCELS MY AUTHORIZATION GIVEN ABOVE.**

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

NPS Staff: \_\_\_\_\_ Date: \_\_\_\_\_



# Northland Psychiatric Specialists, LLC

**Assignment of Benefits and Release of Information:**

I assign any and all insurance benefits directly to NORTHLAND PSYCHIATRIC SPECIALIST, LLC. I authorize the use of my signature on all insurance submissions. NORTHLAND PSYCHIATRIC SPECIALISTS, LLC may disclose any and all information needed to my insurance carrier and their agents for the purpose of obtaining payment for services, determining benefits and authorizing treatment. *I understand that I am financially responsible for all charges for services rendered to me/my dependent by NORTHLAND PSYCHIATRIC SPECIALISTS, LLC.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Treatment Consent:**

I authorize NORTHLAND PSYCHIATRIC SPECIALISTS, LLC physician and/or supervised psychiatric staff to perform any services that my physician deems medically necessary with my informed consent. I understand that it is my responsibility to inform the physician and/or his staff of any changes in my health. I will not hold my physician or his staff responsible for any errors or omissions that I may have made in the relaying of my health information.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Minor Child/Incapacitated Adult Treatment Consent:**

I am the parent/legal guardian of \_\_\_\_\_ and have no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize NORTHLAND PSYCHIATRIC SPECIALISTS, LLC, physician and/or supervised staff to perform any services that the physician deems medically necessary with my informed consent, whether or not I am present during the actual appointment when such treatment is rendered. I understand that I am responsible to inform the physician and/or his staff of any changes in the health of my charge. I will not hold the physician or his staff responsible for any errors or omissions that I may have made in the relaying of health information.

Printed Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Privacy Notice Acknowledgement:**

I acknowledge that I have been advised of the privacy policies for NORTHLAND PSYCHIATRIC SPECIALISTS, LLC. I understand that I have the right to review this policy prior to signing this notice. I understand that, upon requesting from the front office staff, I can receive a copy of the privacy policy. I understand that a copy of the privacy policy is in the waiting room of NORTHLAND PSYCHIATRIC SPECIALISTS, LLC and on the office website at [www.NPSKC.com](http://www.NPSKC.com).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Patient Procedures --Financial Policy Acknowledgement:**

I acknowledge receipt of the patient procedure and financial policies for NORTHLAND PSYCHIATRIC SPECIALISTS, LLC and agree to abide by the procedures and financial policy set in place by NORTHLAND PSYCHIATRIC SPECIALISTS, LLC for the sole purpose of making my overall healthcare experience at NPS the best that it can be.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Electronic Medication History Request Consent:**

I authorize Northland Psychiatric Specialists, LLC to receive my medication history electronically from my pharmacy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_