Kerstin Helgason, PMHNP
8339 Church Street, Suite 114, Gilroy, CA 95020
Phone: (408) 767-2337 Fax: (415) 376-4572
Email: info@gilroymentalhealth.com

***Please bring your ID and insurance card to the first appointment.**

Name (First, Middle Initial, Last) **Nickname or Preferred Name**

Date of Birth **Gender** **Preferred Language**

Home Address **City** **State** **Zip Code**

Mailing Address (if different) **City** **State** **Zip Cod**

Electronic Correspondence Permissions: *Please read disclosure on the last page of this document
****Detailed message means a message which may include health related information:**

1. Phone Number

- Permission to leave voice message? [ ] Detailed** [ ] General [ ] None
- Permission to send text message? [ ] Detailed** [ ] General [ ] None
- Permission to send text appointment reminders? [ ] Yes [ ] No

2. Email Address

- Permission to send email message? [ ] Detailed** [ ] General [ ] None
- Permission to send email appointment reminders? [ ] Yes [ ] No
- Permission to send email invoice and billing statements? [ ] Yes [ ] No

3. Send billing statements and invoices to: [ ] email or [ ] home or mailing address.

Emergency Contact Name **Relationship** **Phone Number**

Legal Guardian Name (if applicable) **Relationship** **Phone Number**

- **Will you be using insurance to pay for care? [ ] Yes [ ] No**
- **Do you have Medicare? [ ] Yes [ ] No**
- **Do you have Medi-CAL or Medicaid? [ ] Yes [ ] No**

Primary Insurance Company Name **Insurance Phone Number**

Subscriber Name **Subscriber Date of Birth** **Relationship to Patient**

ID Number **Group Number**

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Reason for being seen today:

_____

_____

Current Medications:

Please list all prescription and over the counter medications and herbal or vitamin supplements you are currently or frequently take:

Medication Name	Dose	Frequency	Reason for taking
[ ] None			

Medical Problems: (For example: Diabetes, high blood pressure)

[ ] None			

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Women:

Are you pregnant, or any chance you are pregnant? [ ] No [ ] Yes, Due Date _____

Surgeries:

[ ] None		

Allergies to Medications:

Medication Name	Reaction
[ ] None	

Other Providers:

	Name	Phone Number
Primary Care Provider		
Therapist		
Other		

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Office Policies, Consent for Treatment, HIPAA, Electronic Correspondence

Thank you for choosing Kerstin Helgason, PMHNP for your psychiatric care!

Consent for Treatment:

I consent to and authorize Kerstin Helgason, PMHNP, a Psychiatric Nurse Practitioner, to treat me or my dependent. I understand treatment could include psychiatric medication management, psychotherapy, lab testing, medical imaging, psycho-education, or other diagnostic or monitoring tests or treatments and I also have the right to refuse treatment.

Appointments:

Services are available by appointment only and when appointments are made a time is set aside specifically for me. The first appointment is a Psychiatric Evaluation and is usually 60 minutes long, afterwards, follow-up appointments can be 30-50 minutes. Psychotherapy sessions are typically 50 minutes.

Cancellation Policy: **24 hour notice** is required for cancelling an appointment. **There is a $125 fee for not cancelling 24 hours in advance of an appointment or not showing to an appointment.** The fee must be paid before the next appointment.

Contact, Hours, and Emergencies:

My provider can be contacted via phone: 408-767-2337, email: info@gilroymentalhealth.com, or messaging through the health record platform. Messages received after regular business hours may not be listened to or read until the next business day, though every effort is made to return calls within 2 business days.

****Medical or mental health emergency, crisis, or urgent services are not available through this office or provider** and I understand I need to call 911, a mental health crisis line (eg: 1-800-SUICIDE), or go to the nearest emergency department for urgent, emergent, or crisis help.

Prescriptions: Prescriptions are only filled at appointments.

All prescriptions are sent electronically to the pharmacy and I will be provided with enough medication until the next appointment. Prescriptions are only filled at appointments and **if I am running out of medications I will need to make an appointment for additional refills and to monitor my condition.**

Controlled Substances are medications which have the potential for abuse, dependence, or addiction and are highly regulated by the Federal Drug Administration (FDA) and Drug Enforcement Agency (DEA). Controlled substances include pain medication (eg: opiates), anxiety and seizure medications (eg: benzodiazepines), and amphetamine based stimulants. I will be informed if I am started or continued on this type of medication and understand these medications have additional rules that I agree to follow:

1. **Medications (the pills) or the prescription (paper prescriptions) are NOT replaced under any circumstances.**
2. Only one prescriber of a medication class or type, if another person prescribes the same or similar medication, I understand this prescriber will no longer prescribe the medication for me.
3. Only one pharmacy, my pharmacy is selected on this form and I will notify my provider if I change pharmacies.
4. Notify my provider of all prescription medications, over the counter medications, and herbal or vitamin supplements I take.
5. Be responsible for storing pills safely, especially around children, because of risk of overdose or adverse effects when ingested.
6. Not sharing, selling, or otherwise making available my prescription medication for other people.
7. Random and scheduled drug screens are required.
8. Notify my provider if I become pregnant immediately as controlled substances have the potential to cause birth defects.
9. Notify my provider if I have had problems with drug or alcohol in the past, even if I never received treatment, so that further assessment and discussion of the risks and benefits of the medications can be completed.
10. I may be requested to bring pill bottles to appointments or at random times for pill counting or monitoring for safety and compliance.

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11. Evidence of drug or medication abuse may result in the medication being discontinued and the patient possibly being terminated from this office with no additional prescriptions for the medications and the patient may require hospital care or other care if withdrawal symptoms occur. Also, other treating medical providers and law enforcement may be notified depending on circumstances.

Fees:
Fees are negotiated with insurance and can vary based on insurance plans and contracts. A medical billing agent will process insurance claims and collect fees.

When paying for services yourself, the fees are below at the time of publication for reference. Please note, fees change over time and the most up to date fees are available on the provider website: www.gilroymentalhealth.com.

- Psychiatric Evaluation (first appointment): $295
- Follow-up appointment: up to 60 minutes: $225
- No show or Late Cancellation Fee: $125

Payments:
Payments, including copay and deductible payments, can be made by check, cash, or credit/debit/HSA card and are due at the time of service.

Insurance and Financial Responsibility:
Insurance works when insurance companies contract with healthcare providers to provide services at set contracted rates. Services which are 'covered benefits' are paid at the contract fee rate and are considered payment in full and can include a patient responsibility portion of the fee, such as co-payments or deductibles.

Insurance Assignment of Benefits: I authorize payment of benefits from my or my dependent's Medicare, Medicaid, and/or insurance carrier/plan directly to Kerstin Helgason, NP for services provided to me or my dependents. I understand this authorization may not result in full payment from my insurance for the charges incurred and I agree I am financially responsible to make payment for co-payments/deductibles in full or for charges remaining on balances should my/my dependent's insurance determine the services received are not covered, denied, or unpaid for any reason. I understand and agree that records regarding my care can be provided to my insurance for the purpose of obtaining payment and release of records is allowed without written permission under Federal law, HIPAA (The Health Insurance Portability and Accountability Act).

Advanced Beneficiary Notice: If insurance coverage has lapsed, insurance information is not up to date, or payment is denied due to lack of coverage, out of network status, or for any other reason, I am responsible for the bill and payment in full is due at the time of service at the insurance contracted rate or at current "out of pocket" payment rates. Insurance benefits are not verified by my provider prior to my appointments and it is my responsibility to know if I have coverage and to notify my provider of my up-to-date coverage information. I understand I am responsible for appealing unpaid claims with my insurance and providing payment to my provider on denied or otherwise unpaid insurance claims, regardless of the reason.

Insurance Referrals:
Some insurances require a referral for specialty care, including mental health or psychiatric care. **I understand it is my responsibility to ensure a referral has been completed**, usually by my Primary Care Provider, prior to start of service; and accept financial responsibility for services rendered when a referral has not been completed if it is required by my insurance and the services are denied as a result.

Insurance Non-Covered Benefits:
Please be aware that not all services provided are covered benefits. Non-covered benefits are services the insurance does not consider medically necessary and/or are not covered, or paid for, by the insurance. Typical mental health covered services include medication management or psychotherapy appointments (though the insurance can decide they aren't at any time). Common examples of non-covered services are longer than normal sessions, no-show fees, completing forms related to disability or other services, forms for legal purposes, or testimony in legal proceedings. Insurance companies can also decide at any time that usual care, eg: medication management, is not a covered service. These services are billed at hourly rates that may vary based on the type of service.

Uninsured or Not Using Insurance:
I understand that if I have no insurance or if i decide not to use insurance benefits to pay for services for me or my dependents I am responsible for payment on the day of service at the usual rates. If insurance coverage is available, then I may need to complete an Advanced Beneficiary Notice stating I understand services are covered by my insurance(s), but I am

 Patient Name/DOB: _____

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choosing to not submit a bill or claim to insurance and, instead, to arrange for direct payment with my provider in lieu of payment from the insurance.

Privacy, Release of information, and HIPAA:

I understand psychiatric records and information are confidential and can only be released to people or entities with my expressed and/or written consent, except for coordination of care with other treating providers, such as therapists and Primary Care Providers or as allowed by Federal or state law, such as HIPAA (eg: allows release of records to insurance for payment and operations, or to/from other treating providers). I understand a Release of Information can be revoked at any time by providing a written request for revocation; except to the extent action has already been taken on a valid release. In compliance with The Health Insurance Portability and Accountability Act the **HIPAA Notice of Privacy Practices** is available at the office, on the office website (www.gilroymentalhealth.com), and a copy is a available upon request and can be provided electrically or on paper.

Some exceptions to confidentiality include:

- When abuse to a vulnerable person is reasonably suspected, including children, disabled, or elderly people.
- When imminent threats to safety related to harm to oneself and harm to others are reasonable suspected.
- Mandatory regulatory, health, or law enforcement reporting.
- For treatment, payment, and operations related to the provision of healthcare, including billing, or coordination with other treating providers.

Termination or Closure:

I understand that I or my provider can terminate care at anytime for any, or no, reason. Care is considered ongoing when I attend appointments regularly or notify the provider of the need to miss an appointment; **care will be considered automatically terminated at the time an appointment is missed or 90 days after the last attended appointment, whichever is more recent.** Care can be easily re-established by attending another appointment. When care is terminated by the provider for cause (such as abusive or threatening behavior or diversion of controlled substance medication) I may not be provided with any further medications. A 30 days supply of medication typically will be provided when the provider terminates care with a patient under non-cause circumstances, though this is at the discretion of the provider.

***Electronic Correspondence Permissions:**

Email and text messaging (electronic communication) are convenient ways to communicate with your medical provider. With electronic communication, you can send and receive information about your appointments, payments, or health information that is specific to you and your health conditions or treatment. The HIPAA Federal Privacy Rules allow electronic communication about your health conditions or treatment, including email and text messages, to be used as a form of communication, so long as the patient or guardian are aware of the risk of unintended access to information and grant permission. Risks include, but are not limited to, even encrypted communication may not always be secure in transit (eg: hacking), or once information has arrived at the intended destination, other people may be able to access your secure information (eg: a spouse has access to your email account or alerts on your phone may show a message). By contacting your provider via electronic communication you are granting permission for such correspondence, including the associated risks. My preferences/permissions for electronic permissions are selected on the first page of this document, though can be changed by notifying my provider in writing, or by initiating electronic correspondence.

By signing below, I attest I have read, understand fully, and agree to the contents and have provided information accurately. I acknowledge I have been offered or understand where I can review or receive a copy of the HIPAA Notice of Privacy Practices and understand the limits of electronic communication. A copy of this form shall have the same force and effect as the original.

Pharmacy: _____ **Address:**_____

X_____

Patient or Guardian Signature **Printed Name** **Date**