PARAMOUNT HEALTH DIRECTIONS
52 Monroe St.
Denver, CO 80206
(P) 303-393-1726 (F) 303-200-9009

Patient Information:

Patient's Name: _____ Gender: _____

Date of Birth: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile Phone: _____ Work Phone: _____
(Please indicate which phone # you would like to receive confirmation calls. Mark with #1 or circle)

Email: _____

Responsible Party(s) If A Minor:
If you are the parent or legal guardian of a client under the age of 18, please complete the following with your information. If you are over the age of 18, please proceed to the next section of this form.

Parent(s)/ Legal Guardian's Name: _____

Street Address: _____ City/State/Zip Code: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Primary Care Physicians/ Pediatrician Information:

Name: _____

Phone: _____ Fax: _____

Pharmacy Name/ Number: _____

Emergency Contact Information:

Name: _____ Relationship to Patient: _____
Home Phone: _____ Cell Phone: _____

_____ _____

Signature Date

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No Show/ Late Cancellation Policy

We strongly reinforce full compliance with our 24 hour notice cancellation policy. We are a private medical office with a high volume of patients and an ongoing waiting list. We ask that you cancel your appointment with a minimum of 24 hours' notice (cancellations for Monday appointments need to be made by Friday before 3pm) in order to allow us to serve other patients in need of immediate attention. We are usually booked 2-3 months in advance, therefore learning of available appointment times in a prompt manner increases our ability to serve our patients better. Patients who cancel appointments with less than 24 hours' notice or do not show up for scheduled appointments will be charged the full amount of the session they were scheduled for. We allow no exceptions to this policy and every patient will be held accountable for their scheduled appointment time. *The card you provide will be automatically charged for these appointments. *

I have read the no show/cancellation policy. I understand and agree to the terms of the policy. I understand that I am responsible for payment of any appointments I cancel with less than 24 hours' notice or appointments I do not show up for.

Signature of Patient/ Legal Guardian: _____ Date: _____

Informed Consent for Telemedicine Services

Under special circumstances our providers may be able to provide you with telemedicine services. What this means is that your healthcare provider can interact with you through interactive video connection, text, email, or phone, in order to consult with you about your condition. By signing this consent form you are authorizing this communication to take place should it be approved by your healthcare provider. Again, our providers are only able to offer this under special circumstances that must be discussed with the provider and approved by them directly. This authorization does not guarantee you the offering of these services.

Potential risks of technology:

1. The video/phone connection may not work or that it may stop working during the consultation.
2. The video picture of information transmitted may not be clear enough to be useful for the consultation.
3. I may be required to go to the location of the healthcare provider if it is felt that the information obtained via telemedicine was not sufficient enough to allow for appropriate medical decision making.
4. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information.
5. We do not have a secure server for emails. Emails and texts should contain as little personal information as possible and will be sent at your own risk.

By signing this form, I understand the following:

I understand that the laws that protect privacy and confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.

I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.

I understand other individuals may be present to operate the video equipment and that they will take reasonable steps to maintain confidentiality of the information obtained.

I understand that I have the right to ask my healthcare provider to discontinue the conference at any time. However, I also understand that I will still be charged for the full amount of the scheduled conference. I have read this document and understand the risks and benefits of telemedicine. I hereby consent to participate in a telemedicine visit under the conditions described in this document.

I hereby authorize Paramount Health Directions to use telemedicine in the course of my diagnosis and treatment, should my healthcare provider feel it is appropriate and necessary.

Signature of Patient/ Legal Guardian: _____ Date: _____

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ELECTRONIC PAYMENT AUTHORIZATION

Please indicate the card you wish to use for all services rendered through this practice. Charges for services rendered will be deducted from the card designated below at the time services are rendered.

Client Information:

Client Name: ____ Date of Birth: ____________

Address: __________________________ City: _______________ State: ______ Zip: ______

Home Number: ________________ Mobile Number: ________________ SSN: __________

Email: ____

Billing Information:

Name: ____

Address: ___________________________ City: ____________ State: ______ Zip: ________

Email: ____

I authorize all service fees (including No Show/ Late Cancel Appointments) to be deducted from the card ending in ___________ (last four digits of the card)

I authorize the use of this card for all services and fees at the time they are rendered for the following parties: Full Name(s) ____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. *By authorizing use of this card and signing this electronic payment authorization form, I certify that I am the cardholder and my signature below authorizes each individual charge for all dates of service.

____ ______________________
Cardholder Signature **Date**

Payments are processed by Therapy Partner.
Therapy Partner is a registered ISO/MSP'of Fifth Third Bank, Cincinnati, OH and HSBC Bank USA National Association, Buffalo, NY.

_ _

Please provide your payment information below. The card information you provide on this form will be destroyed once your information has been securely encrypted and stored.

Card (circle one): Visa MasterCard Discover Security Code: ________

Card Number: ___________________________________ Expiration Date: _____________

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Paramount Health Directions Communication Consent Form

I, _____, hereby give the staff at Paramount Health Directions permission to call, email, or leave voicemails with information pertaining to:

- Appointment Information/ Confirmation
- Lab Results
- Online Billing Statements
- Account/ Billing Information
- Prescription Information
- Referral Information

Preferred method of communication

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Email: _____

My information may be discussed with those listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

_____ _____

Signature of Patient/ Legal Guardian Date

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OFFICE POLICIES AND PROCEDURES

Please keep this copy for your records

Standard Service Fees:

Please review the rates for the following services on your provider's financial policy form.
Psychiatric or therapeutic sessions lasting over 55-minutes in length may be subject to additional service fees.

- Individual Adult, Adolescent, Child, Couple, or Family Sessions
- Professional Consultation
- If a report, letter, or consultation with an outside party is requested, I understand I will be billed for any time needed to prepare documentation or to conduct an in-person or phone consultation. My provider's standard service fee (detailed above) will apply.

Forms of Payment & Payment Policies:

This practice accepts the following forms of payment: Visa, MasterCard, Discover, and personal checks or cash. Patients will be responsible for payment at the time services are rendered.

Cancellation Policy:

In the event you need to cancel an appointment, please provide notice to the PHD staff within 24 hours of your scheduled appointment time. If sufficient notice of a cancellation is not provided, or no notice is given at all, your provider's standard service fee as agreed upon in the disclosure will be assessed for the session and charged to the card on file.

Medication Refills:

- Please allow **a minimum of 2 business days** for all refill prescriptions.
- To ensure prompt service on refills, you will need to be seen every 90 days. Please call our refill line at ext #2 and leave a message with your request, the voice mails are checked throughout the day.
- Refills will not be approved on Holidays, weekends, or after hours, so plan accordingly to ensure you do not run out of medication. Remember that certain medications do not allow for additional refills and will require you to have a new prescription each month.
- If your insurance requires a prior authorization, be aware their standard policy can take up to 3 business days for their decision. Medication refills are not considered an emergency and will not be addressed after hours.

Insurance:

This private practice does not directly bill through any insurance or medical plan; however, insurance-ready statements with all necessary diagnostic information, dates of service, and service codes included, will be securely encrypted and emailed to you at the end of each month, detailing direct payments you have made to the practice. These statements can be used to initiate the reimbursement process privately through your insurance company.

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Controlled substance medications are very useful, but have a high potential for misuse and are therefore closely controlled by local, state and federal governments. My physician is prescribing controlled substance medications to help manage my symptoms, therefore I agree to the following:

1) I am responsible for the controlled substance medications prescribed to me.

_____ **a)** If my prescriptions are misplaced, stolen, or I run out early, I understand that this medication **will not be replaced** regardless of the circumstances.

2) Refills of controlled substance medications;

_____ **a)** will be given during a scheduled office visit or by request during regular office hours, Monday thru Friday with a minimum of 48 hours notice. Refills will not be made at night, during the weekends or holidays.

_____ **b)** I am solely responsible for taking the medication as prescribed and for keeping track of the remaining medication.

_____ **c)** I understand that I must be seen by my doctor a minimum of every 90 days in order to continue to receive my medications.

_____ **d)** I understand that controlled medications do not allow for added refills and will require a new one every month.

3) I am responsible for taking my medication exactly as prescribed.

_____ **a)** I understand that my doctor at Paramount Health Directions is the only doctor who can prescribe these medications for me. I understand that I am in violation of this contract if I obtain these medications from another provider outside of Paramount Health Directions.

_____ **b)** I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from another individual, or use of non-prescribed illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

____ **c)** I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit digs, or abuse of controlled medications, I may be subject to dismissal from this facility.

____ **d)** It is the policy of our practice to periodically perform drug screenings to ensure compliance.

4) Potential risks and side effects;

_____ **a)** I acknowledge that my doctor has discussed potential risks and side effects of the medications being prescribed and has instructed me on what to do should I experience harmful side effects.

_____ **b)** I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances and that my physician will advise me of advances in the field and will make necessary treatment changes.

I understand that by signing this contract I agree to abide by the above listed terms and conditions.

Patient Name: _____ Date: _____

Patient Signature: _____