Patient Registration Packet

For the Practice of

Michael K. Smith, M.D., P.A.
Child, Adolescent, Adult and Forensic Psychiatry
745 Johnnie Dodds Boulevard, Suite A
Mt. Pleasant, South Carolina 29464
Phone: 843-906-5972 / Facsimile: 843-284-8277

Please complete this packet if you are a new patient.

Michael K. Smith, M.D.
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Contact and Emergency Information

I attempt to return phone calls within the same business day if the message is left during regular business hours on Wednesday thru Friday (9:00 a.m. – 5:00 p.m.). Otherwise I will review and return messages on the following business day with the exception of messages left on Friday after hours, which will be returned on the following Wednesday (since I am not in Charleston Sunday through Tuesday).

If you are an established patient and have an emergency you may call my telephone number, follow the instructions on the phone message (which might change from time to time) and select the option of leaving a call back number, which will page me, and then leave a voice message with your name and contact information including location. If your call involves a psychiatric emergency, please get to the nearest emergency room immediately for emergent evaluation and stabilization and/or call 9-1-1 immediately and continue to try and contact me. Even the best contact systems fail at times so please remember the emergency room and 9-1-1 are among the best available and most accessible resources during a psychiatric emergency. Please understand that in the event of a psychiatric emergency, my own response would likely include the use of local emergency resources such as the 911 system and local emergency rooms, so please do consider these as first resources during a psychiatric emergency.

It is important to note again that I am not in the Charleston area from Sunday to Tuesday evening. In the event of an emergent need during this time, please leave a message as described above and/or follow directions left on office phone message. Again, in the event of a psychiatric emergency please go to the nearest emergency room and/or contact 9-1-1 as described above. Otherwise, please note that my regular office hours are Wednesday – Friday, 9:00 a.m. – 5:00 p.m.

I have carefully read and agree to all the terms of the above guidelines and have had an opportunity to discuss my questions.

Signature _____ Date _____

Michael K. Smith, M.D., P.A.

Registration Sheet

Date:_____

Patient Last Name:_____First:_____MI:_____

Date of Birth: ____/____/____ Age:_____ SSN: _____-____-_____

Mailing address:_____

City _____State_____Zip_____

Home phone: (_____)_____ May a message be left at this number?___yes ___no

Work phone: (_____)_____ May a message be left at this number?___yes ___no

Cell phone: (_____)_____ May a message be left at this number?___yes ___no

Pager: _____

How do you prefer to be contacted? _____

Would you like to receive invoices &/or statements via email? ___yes ___no

Email address (to be used for billing purposes only): _____

Referred by: _____

In case of emergency, contact:

Name: _____ Relationship: _____

Contact number(s): _____

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Fee Schedule and Payment Agreement for Child, Adolescent and Adult Services

Initial Evaluation (Adult): This includes an initial assessment of 55 minutes ($220), a comprehensive history, review of records as permitted, correspondence with referring physician or clinician and agencies as requested, and administrative time establishing a file.

A second follow-up assessment session of 45 minutes ($180) is required, unless otherwise indicated. Fee for both sessions is $400.

Initial Evaluation (Child): This includes two initial sessions, the first is a 75 minute session ($270) which is followed by a second 45 minute session ($180). Sessions will include child and child's parents or guardians. Evaluation also includes a comprehensive history, review of records as permitted, report preparation if indicated, correspondence with referring physician or clinician, schools or other agencies as requested, and administrative time establishing a file. The fee is $450.

Individual Psychotherapy and/or Medication Management

-20 minute session $120
-45 minute session $180

Family or Couple's Therapy

-45 minute session $180
-75 minute session $220

Phone Consultation (during business hours, time permitting)

-First 10 minutes per month no charge
-Every 15 minute increment afterward, $60

School/Home Visit (upon special request)

-Per hour, including travel within Charleston and Dorchester Counties, $180

Generation of requested report or correspondence

-Per hour effort $180

Fees may be changed at provider's discretion with prior notice.

FEE AGREEMENT

- I understand that fees are due as stated and are to be paid at each session.
- I accept full financial responsibility for any missed appointments OR appointments cancelled with less than a 48 hour notice. The missed appointment fee is the full fee of the missed appointment and is not billable to my insurance company.
- I have carefully read all the terms of the above guidelines and have had full option to discuss any questions or concerns with these terms.

Signature of Responsible Party_____ Date_____

Printed Name of Responsible Party/Patient _____

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Non-Assigned Payment Waiver: Non-Participating Insurance Plans

Patient Names:_____
Insurance Plan/ID#: _____

I have consented to treatment by Michael K. Smith, M.D., P.A. and understand that he is NON-PARTICIPATING in my insurance plan. I request that Dr. Smith conduct therapy and/or medication management regardless of the possibility that I may receive no insurance reimbursement for these treatments and I agree to undertake full responsibility for payment of the fees incurred at the time of each visit.

I understand that at my request, I will be given the necessary billing codes for the type of treatment I receive from Dr. Smith. These billing codes can be submitted to my insurance provider for any partial reimbursements for which I am contractually eligible.

Patient (or Patient's Personal Representative)Signature:_____
Date:_____
Witness:_____

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Insurance Guide

Please retain for your use.

I do not file insurance plans, however, I will provide you with the necessary documentation you will need to file your insurance claim yourself.

You may wish to contact your insurance company to determine whether or not they will pay "out of network benefit." Below is a checklist/guide which might prove useful to you in getting the information you need from your insurance company. I recommend that you document all information you are given over the phone including the time and content of the conversation and to whom you are speaking. Provided below is space for documenting this information.

- Date and Time of call/s:
- Verify that the number you have called is the one to call regarding mental health benefits.
- Write down the name of each person with whom you speak.

- Ask if outpatient mental health benefits are covered.
- Ask if you need a referral from your primary care physician.
- Ask how much of the initial evaluation fee is covered/total dollar amount covered.
- Ask the maximum number of sessions allowed per year by your company.
- Ask the maximum dollar amount covered by your insurance company for outpatient mental health, per year and overall.

- Ask what your deductible dollar amount is.
- Ask whether you have met the deductible.

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Authorization to Disclose Protected Health Information

Patient Name: _____ Date of Birth: _____
I authorize Michael K. Smith, M.D., P.A. to disclose/release information to and obtain information from:
Name of organization or person: _____
Address: _____
Phone Number(s): _____ Fax Number: _____
The purpose of the disclosure is:_____

__Entire Record	__Consultation Report
__Diagnoses	__Summary of Initial Evaluation
__Medication List	__Discharge Summary
__Laboratory Results	__Other:_____

I understand that AI have the right to cancel/revoke this authorization at any time. I understand that if I wish to cancel/revoke this authorization, I must do so in writing and present my written cancellation/revocation to Michael K. Smith, M.D., P.A. I also understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization, as stated in the Notice of Privacy Practices. Unless otherwise cancelled/revoked, this authorization will NOT expire.

I understand that a reasonable, cost-based fee for copies of protected health information and postage fees will be charged. I understand that the transfer of the above information may involve written, printed or verbal communication and may occur by phone, fax, email or direct person to person communication.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and/or copy the information to be disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person or organization receiving the information, as detailed in Notice of Privacy Practices. I understand I may be given a copy of this authorization.

Signature of Patient (or patient's personal representative—describe) _____

Printed Name of Patient or representative_____Date_____

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Name of organization or person: _____
Address: _____
Phone Number(s): _____ Fax Number: _____
The purpose of the disclosure is:_____

__Entire Record	__Consultation Report
__Diagnoses	__Summary of Initial Evaluation
__Medication List	__Discharge Summary
__Laboratory Results	__Other:_____

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Signature of Patient (or patient's personal representative—describe) _____

Printed Name of Patient or representative_____Date_____

Patient Privacy

MICHAEL K. SMITH, MD
HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date (2010)

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice, please contact: Michael K. Smith, M.D., P.A. at (843) 906-5972. This notice describes the privacy practices at my office.

I am committed to protecting the privacy of information I gather about you while providing you with healthcare. Some examples of protected health information are:

- Information about your health condition (such as diagnosis)
- Information indicating you are a patient of my practice
- Information about health care products or services you have received or may receive in the future (such as an operation or diagnostic imaging)
- Information about your health care benefits under an insurance plan (such as whether a prescription is covered)

When combined with:

- Demographic information (such as your name, address, insurance status)
- Unique numbers that may identify you (such as your social security and phone numbers)
- Other types of information that may identify who you are.

REQUIRED PERMISSION TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

I will obtain a one-time general written consent to use and disclose your health information in order to treat you, obtain payment for that treatment and conduct my business operations. This general written consent will be obtained the first time I provide you with treatment or service. This general written consent is a broad permission that does not have to be repeated each time I provide treatment or services to you.

I will generally obtain your written authorization before using your health information or sharing it with others. You may also ask that I transfer your records to another person by completing a written authorization form. If you provide me with written authorization, you may revoke that written authorization at any time, except to the extent that I have already relied upon it or taken action to do what you previously requested. To revoke a written authorization, please write to me at: Michael K. Smith, M.D., P.A., 745 Johnnie Dodds Blvd., Suite A, Mt. Pleasant SC 29464.

Initials _____ Date _____

We are required by law to:

* Maintain the privacy of protected health information * Give you this notice of our legal duties and privacy practices regarding your health information * Follow the terms of the notice currently in effect.

HOW WE MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

I may use your health and share it with others in order to treat you in an emergency or to meet important public needs. I will NOT be required to obtain your general written consent before using or disclosing your information for these resources. I will, however, obtain your written authorization for, or provide you with an opportunity to object to the use and disclosure of your health information in these situations when state law specifically requires that I do so.

Described as follows are the ways we may use and disclose your health information. Except for the following purposes we will use and disclose your health information only with your written permission. You may revoke such permission at any time by writing to Michael K. Smith, M.D., P.A.

Appointment Reminders, Treatment Alternatives, and Health- Related Benefits and Services. We may use and disclose your health information to contact you and remind you of your appointment, to tell you about treatment alternatives or health-related benefits and services you could use.

As Required by Law. We will disclose your health information when required to do so by international, federal, state or local law.

Business Associates. We may disclose your health information to our business associates that perform functions on our behalf or provide us with services if necessary. For example, we may use another company to perform billing services on our behalf. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose the information for any other purpose than appears in their contract with us.

Coroners, Medical Examiners, and Funeral Directors. We may release your health information to a coroner, medical examiner, or funeral director to identify a deceased person or cause of death, or other similar circumstance.

Emergencies. I may use or disclose your health information in order to treat you, to obtain payment for that treatment and to conduct our business operations if you need emergency treatment or I am required by law to treat you but am unable to obtain your general written consent. I will attempt to obtain your general written consent as soon as I am reasonably able to after I have treated you.

Health Care Operations. We may use and disclose your health information to evaluate and improve our medical care and to operate and manage our office. For example, we may use and disclose information to a peer review organization or a health plan that is evaluating our care. We may also share information with others that have a relationship with you for their health care operation activities.

Initials _____ Date _____

Health Oversight Activities. We may disclose your health information to a health oversight agency for activities authorized by law. These may include audits, investigations, inspections, and licensure. These activities are necessary to for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Individuals Involved in Your Care or Payment for Your Care. When appropriate, we may share your health information with a person involved in, or paying for, your care (such as your family or a close friend). We may notify your family about your location or condition or disclose such information to an entity assisting in disaster relief.

Inmates or Individuals in Custody. If you are an inmate of a correctional institution or in custody we may disclose your information 1) for the institution to provide you with health care, 2) to protect your health and safety or that of others, and 3) for the safety and security of the institution.

Law Enforcement. We may release your health information request by law enforcement official if 1) there is a court order, subpoena, warrant, summons or similar process; 2) if the request is limited to information needed to identify or locate a suspect, fugitive, material witness, or missing person; 3) the information is about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain your agreement; 4) the information is about a death that may be the result of criminal conduct; 5) the information is relevant to criminal conduct on our premises; and 6) it is needed in an emergency to report a crime, the location of a crime or victims, or the identity, description, or location of the person who may have committed the crime.

Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose your health information in response to a court or administrative order. We may disclose your health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested. In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation or are anticipating litigation and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. My testimony may also be ordered in other cases including legal proceedings relating to psychiatric hospitalization, malpractice and disciplinary proceedings, court-ordered psychological evaluations and certain legal cases following the death of a patient.

Under current South Carolina law, all participants in group, couples and family therapy are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

Medical Records. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records must be made available to the patient's appropriate designee.

Initials _____ Date _____

Military and Veterans. If you are a member of the armed forces, we may release your health information as required by military command authorities. If you are a member of a foreign military we may release your health information to the foreign military command authority.

National Security and Intelligence Activities. We may disclose your health information to authorized federal officials for intelligence and other national security activities authorized by law.

Notice to minors. If you are under eighteen years of age, please be aware that your parents have a right to receive general information on the progress of your treatment. Your parents may also request a copy of your record.

Payment. We may use and disclose your health information so that others or we may bill and receive payment from you, an insurance company, or a third party for the treatment and services you received. For example, we may give information to your health plan so that they will pay for your treatment.

Product Monitoring, Repair and Recall. I may disclose your health information to a person or company that is regulated by the Food and Drug Administration for the purpose of: 1) reporting or tracking product defects or problems; 2) repairing, replacing or recalling defective or dangerous products; or 3) monitoring the performance of a product after it has been approved for use by the general public.

Public Health Risks. We may disclose your health information for public health activities to prevent or control disease, injury or disability. We may use your health information in reporting births or deaths, suspected child abuse or neglect, medication reactions or product malfunctions or injuries, and product recall notifications. We may use your health information to notify someone who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition. If we are concerned that a patient may have been a victim of abuse, neglect, or domestic violence we may ask your permission to make a disclosure to an appropriate government authority. We will make that disclosure only when you agree or when required or authorized to do so by law.

Research. We may use and disclose your health information for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition. Before we do so, the project needs to go through a special approval process. Even without special approval, we may permit researchers to look at records to help identify patients who may be included in their research, as long as they do not remove or copy any of your health information.

To Avert a Serious Threat to Health or Safety. We may use and disclose your health information when necessary to prevent a serious threat to the health and safety of you, another person, or the public. Disclosures will be made only to someone who can prevent the threat.

Treatment. We may use and disclose your health information for your treatment and to provide you with treatment- related health care services. For example, we may disclose your health information to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.

Initials _____ Date _____

Victims of Abuse or Neglect. I may release your health information to a public health authority that is recognized to receive reports of abuse or neglect. For example I may report your information to government officials if I reasonably believe that you have been a victim of such abuse or neglect. I will make every effort to obtain your permission before releasing this information but in some cases I may be required or authorized to act without your permission.

Worker's Compensation. We may release your health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness.

INCIDENTAL DISCLOSURES

While I will take reasonable steps to safeguard the privacy of your health information, certain disclosures of your health information may occur during or as an unavoidable result of my otherwise permissible uses or disclosures of your health information.

CONFIDENTIALITY AND COMMUNICATIONS

At times I may use a cellular phone or voice-over-internet phone to contact you or return your calls. Please be aware that I will NOT notify you when I am using such a devise so if you feel the information discussed requires a more secure level of confidentiality, please let me know so arrangements can be made to contact you in another way.

I generally discourage email and texting as a mode of communication due to confidentiality concerns. I may reply to these methods but will make every effort to limit the type of information included due to these confidentiality concerns. Again email and texting is NOT A CONFIDENTIAL MODE OF COMMUNICATION and are generally not used in this office.

I do routinely use a fax machine in communication with other clinicians and agencies. I will only release information that you have authorized me to release and this information will be sent with a cover sheet that includes confidentiality statement. This cover sheet cannot insure that the fax is received in the proper place or is handled in a confidential manner once it is received. You may pick up and hand carry documents to agencies/clinicians if you wish and I will also mail documents on special request.

I can do all of these things if you have signed a general written consent form. Once you sign this form, it will be in effect indefinitely until you revoke it or specify date for termination. You may revoke your general written consent at any time, except to the extent that I have already relied upon it. To revoke your general written consent, please write to: Michael K. Smith, M.D., P.A., 745 Johnnie Dodds Blvd, Suite A, Mt. Pleasant SC 29464.

Initials _____ Date _____

CHANGES TO THIS NOTICE

In order to stay current with new state and federal laws, I may change this notice and make it effective for medical information I already have about you as well as new information. The current notice will be posted and available at all times. You have a right to request a paper copy of the current notice at any visit or by written request to Michael K. Smith, M.D., P.A., 745 Johnnie Dodds Blvd., Suite A, Mt. Pleasant SC 29464.

ACKNOWLEDGEMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, and how I may obtain information. Finally by signing below, I consent to the use and disclosure of my health information to treat me and arrange my medical care, to seek and receive payment for services given to me and for the business operations of this practice.

_____

Signature of Patient or Patient's Personal Representative (describe authority)

_____

Printed Name of Patient and Patient's Personal Representative

_____

Date

SPECIFIC UNDERSTANDINGS

In the course of providing treatment to you I may use your health information to contact you with a reminder that you have an appointment for treatment or services at my office. In my interactions with you I may use a cellular or voice-over-the-internet phone. If you feel the information we are discussing requires a higher level of security, please let me know so arrangements can be made to contact you in another way. Email is not a confidential mode of communication, and though I may reply to emails, I will use every effort to limit the type of information discussed due to these confidentiality concerns.

I also routinely use a fax machine in communication with other agencies. I will only release information you have authorized me to release and will send this with a cover sheet with a confidentiality statement. This does not insure that the fax is received in the proper place or handled in a confidential manner once received. You may pick up and hand-carry documents to agencies if you wish. I will also mail documents on special request.

By signing this authorization form, you authorize the use or disclosure of your protected health information as described on the preceding pages. You should note that when your protected health information is disclosed to people or entities that are not required to abide by federal or state medical privacy laws, those people or entities may re-disclose your information to others and use your information without being subject to penalties under those laws.

You have a right to refuse to sign this authorization. Your health care, the payment for your health care, and your health care benefits will not be affected if you do not sign this form.

You also have a right to receive a copy of this form after you have signed it.

If you sign this authorization, you will have the right to revoke it at any time, except to the extent that our practice has already taken action based upon your authorization. To revoke this authorization, please write to me at: Michael K. Smith, M.D., P.A., 745 Johnnie Dodds Blvd., Suite A, Mt. Pleasant SC 29464.

I have read this form and all of my questions about this form have been answered to my satisfaction. By signing below, I acknowledge that I have read and accept all of the above.

_____

Signature of Patient or Patient's Personal Representative (describe authority)

_____

Printed Name of Patient and Patient's Personal Representative

_____

Date

Patient Health Information Form

Patient's Name _____ **Date of Birth** _____

Allergies to food, medications, other _____

Current Family Physician: _____ **Date of last physical:** _____

Are there currently or have there previously been problems with any of the following?

	Yes	No		Yes	No
Skin problems			Eating		
Wounds not healing/easy bruising			Alcohol		
Glaucoma/vision			Street drugs		
Gum(s)/Teeth			High blood pressure		
Hearing			Heart disease/chest pain		
Headaches			Rheumatic fever		
Head injuries			Nausea/vomiting		
Black outs/fainting			Ulcers		
Numbness/tingling			Liver disease/jaundice		
Thyroid problems			Ulcers		
Blood sugar			Kidney/bladder problems		
Sickle cell			Pregnancy (Due date_____)		
HIV/AIDS			Sexual function		
Fatigue			Difficulty walking/standing		
Anemia/Low blood count			Pain		
Breathing/shortness of breath			Sleeping too much		
Fever			Sleeping too little		
Gallstones			Lead/chemical exposure		
Cancer			Seizures		
			Change in weight		

Please describe:_____

_____

Have any family members had any of the following?

	Yes	No	Who
Depression			_____
Bipolar disorder			_____
Suicide			_____
Schizophrenia			_____
Eating disorder			_____
Anxiety disorder			_____
Alcohol/drug problems			_____
ADHD			_____
Thyroid problems			_____
Asthma			_____
Diabetes			_____
Stroke			_____
Dementia/senility			_____
Stomach problems			_____
Seizures (what kind)			_____
Heart problems			_____
Cancer (what Kind)			_____
High blood pressure			_____
Abnormal heart rhythm			_____
Sudden cardiac death			_____
Tics			_____

Have there been hospitalizations for any medical reasons such as illness, accidents, operations or tests?

Reason for Hospitalization	Date	How long?

Current Medications (including any over-the-counter or herbal preparations):

Name of Medication	Dosage	For What Reason	How Long	Side effects (if any)

Other Psychiatric Medications which have been taken in the past:

Name of Medication	Dosage	For What Reason	How Long	Side effects (if any)

Psychiatric care in the past (such as psychologist, psychiatrist, social worker, nurse, counselor or psychological testing)

For What Reason	When	By Whom	Type of Treatment	Were you hospitalized?

Currently using caffeine? ❒ Yes ❒ No **If yes, how much, how often?**_____

Currently using cigarettes? ❒ Yes ❒ No **If yes, how much, how often?**_____

Currently using alcohol? ❒ Yes ❒ No **If yes, how much, how often?**_____

Signature **Date**