Vest Psychiatric Services, LLC
2935 Pine Lake Road, Suite F
Lincoln, NE 68516
Phone: 402-817-0897
Fax: 402-817-0901

Tina Vest, APRN, CNP
Gerry Merck, LIMHP, LADC
Dr. Barb Eckert, Psy.D.

PATIENT'S RIGHTS AND RESPONSIBILITIES

As a patient you have the right to:

- Include or exclude family members/significant others in all aspects of your care.
- Be treated with compassion, dignity, and respect.
- Be informed of your treatment including benefits, risks, and reasonable alternatives as well as the risks treatment is refused.
- Participate in the decisions of your treatment plan.
- Understand the treatment modalities being used in your treatment, as well as their benefits and consequences.
- Waive the privilege of confidentiality by signing a release of information.
- Refuse treatment.
- A clear understanding of fees associated with care.
- Be free from verbal, physical, psychological, and sexual abuse.
- Confidentiality to the extent to which the law allows:
  - Exceptions include: suspected child/elder abuse/neglect, potential harm to oneself or others, court ordered treatment and instances when the court subpoenas records.
- Receive an explanation and understand the benefits and/or side effects associated with the use of medications being prescribed.

As a patient you have the responsibility to:

- Provide accurate and complete information about your present complaints, past illnesses, prior hospitalizations, types of medication(s) currently using or have used in the past, and other health related issues to your provider.
- Accept responsibility of your decision if refusing treatment.
- Treat others with dignity and respect, including staff, other patients, and providers.
- Respect the property of other persons and Vest Psychiatric Services, LLC
- Assume responsibility for financial obligations.
- Understand and participate in your treatment plan.
- Attend all scheduled appointments and to give 24 hour notice to cancel or reschedule. Understand confirmation calls/notifications are done as a courtesy. Failure to call may result in your discharge from care at Vest Psychiatric Services, LLC, being assessed a no show of **$50.00** per appointment.
- Ask questions about your care.
- Follow your treatment plan.
- **DO NOT** bring alcohol, drugs, weapons, or sharp objects to your appointments.

Print Patient Name: ___________________________________Date of birth: _____________________

Signature of Patient or Legal Representative:_____________________________Date: _________________
(If signed by other than patient, state relationship & authority to do so)

Witness____ Date:_________________

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CONSENT FOR TREATMENT

This form is to document that I, __________________________, (your name) hereby give my permission and consent to

Vest Psychiatric Services, LLC to provide mental health services to me or give my consent for the minor or person under my legal

guardianship _________________________(patient name).

I understand that: **(please initial)**

_____While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and or mental health treatment; I realize that particular results cannot be guaranteed.

_____Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make to make life changes.

_____The clinician is not providing any emergency services. After hours, holidays or weekends I am to contact 911 or go to the nearest emergency room in the event of a mental health emergency.

_____Regular attendance will assist in maximum benefits. I have been advised that I am free to discontinue treatment at any time. If I decide to discontinue treatment I will notify the clinician at least two weeks in advance so that effective planning or continued care can be implemented.

______Conversations with the clinician will remain confidential; with the exception of reporting actual or suspected child or elder abuse/neglect to appropriate authorities, and to protect any one I may threaten with violence, harmful or dangerous actions (including self-endangerment). The clinician is required by law, and has the legal responsibility to report unlawful actions if they cannot be resolved.

I know of no reason why I should not or cannot undertake this counseling and/or mental health treatment and agree to participate fully and voluntarily.

Signature of Patient or Legal Representative:______________________________________ Date: ____________________

(If signed by other than patient, state relationship & authority to do so)

Witness____ Date:_________________

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FINANCIAL POLICY

I would like to take this opportunity to welcome you to my office. In the efforts to try to prevent any misunderstandings that may occur regarding the financial and billing policies, please take a moment to read the following information. If you happen to not have insurance, or have out of network insurance, payment is due at the time services are rendered. To assist you I do accept cash, checks and all major credit cards. There is a service charge of $37.00 for each returned check. If you do have in network insurance, I will file your primary and secondary insurance for you as a courtesy for the following insurance companies that I accept assignment of benefits for:

Blue Cross Blue Shield of Nebraska, Midlands Choice, Medica, Aetna, Cigna, Nebraska Medicare, Wellcare of Nebraska and Nebraska Total Care

Please note exceptions below:
Tina Vest, APRN, CNP is not network for United Health Care, Medica CHI, Blue Cross Blue Shield CHI or Coventry
Gerry Merck, LIMHP, LADC is not in network for United Health Care, Medica CHI, Blue Cross Blue Shield CHI, Medicare or Coventry
Dr. Barb Eckert, PsyD is not in network with United Health Care, Medica CHI, Blue Cross Blue Shield CHI or Coventry

As a courtesy we check insurance eligibility and provider network status; however, it is ultimately your responsibility to ensure the provider is in network if you wish to have in network coverage for your visits.

It is your responsibility to provide my office with up to date insurance information, change of address, change of phone number and change of guarantor. **You must realize, however, that your insurance is a contract between you and your insurance company. Payment to us is your responsibility.** Deductible, co-insurance and copay may be calculated and collected at the time of your visit. If we are unable or do not have access to this information you will be billed for any remaining cost of the visit. Please keep in mind that if the service is not a covered benefit in your insurance plan, you are responsible for the payment in its entirety via the **Self Pay Fee Schedule.**

Any accounts with no payment activity for 90 days will be turned over to an outside collections agency. I do not offer payment plans beyond this time frame.

In case of divorce, the parent signing this financial policy is responsible for any and all payments of services. Any legal agreements, or disagreement, between two parties in a divorce must be dealt with between those parties and does not involve Vest Psychiatric Services, LLC.

If you have any further questions regarding the above information, please call us at (402) 817-0897 and my office staff will be glad to discuss this with you.

AUTHORIZATION

I have read and agreed to the terms and conditions listed above. I hereby authorize the release of any medical information necessary to process my health insurance claims through direct to insurance claims submission or medical billing clearinghouse TriZetto. I authorize payment of benefits directly to Vest Psychiatric Services, LLC. I understand that I am financially responsible to Vest Psychiatric Services, LLC & it's independent contractors as listed above.

Print Patient Name: _______________________________ Date of birth: ______________

Signature of Patient or Legal Representative:_____________________________Date: ___________________
(If signed by other than patient, state relationship & authority to do so if not a blood relative)

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Self Pay/ Out of Network Fee Schedule Effective 1/1/2018

Description of Service	Cost
Outpatient Evaluation 45-60 minutes	$300.00
Appointment 31-60 minutes	$250.00
Appointment 16-30 minutes	$190.00
Appointment 15 minutes	$130.00

Please initial the following:

______ I understand if I'm not using insurance or the provider is "out-of-network", 100% of payment is due at the time of service. The office **cannot** bill insurance and give a self-pay discount due to insurance regulations.

______ I understand if I have an insurance plan with a deductible, $100.00 is due at time of services rendered.

______ I understand I will receive a 10% discount if I pay the above fees in full at time of services rendered.

Print Patient Name: _______________________Date of birth: _________________

Signature of Patient or Legal Representative:____________________________Date: ____________________
(If signed by other than patient, state relationship & authority to do so)

Witness____ Date:________________

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Cancellation/ No Show Policy

Our goal is to provide our patients with high quality care in a timely manner. With a current up rise in the number of patients who are not showing for their scheduled appointments, we have decided to implement a cancellation/ no show policy. We understand that in certain situation, you must cancel your appointment. Please call to cancel at least 24 hours in advance. This allows us adequate time to fill your appointment slot with another patient who needs access to our physicians and staff.

Patients who do not show up for their appointment, without a call to cancel at least 24 hours ahead of time, will be considered a **NO SHOW/LATE CANCEL**. This will be documented in our system, and if you need to call and make another appointment, you may be charged a fee of **$50.00 and up to the full amount of the appointment**, to be paid in full, before being allowed to make that appointment. This will not be covered by your insurance.

Patients who do not show for their appointment (s) 2 or more times, will be considered for dismissal from the practice. This will be at the discretion of the provider, and dismissal will result in denial of any future treatment/appointments by our practice.

Please sign below indicating that you have read and understand the cancellation/no show policy, and agree to abide by the guidelines.

Print Patient Name: ____Date of birth: _________________

Signature of Patient or Legal Representative:____Date: ____________________
(If signed by other than patient, state relationship & authority to do so)

Witness____ Date:_______________

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I, the undersigned, have read and understand the ***Notice of Privacy Practices***

Patient Name (Print): ____

Patient Signature: ____

Date: _________________

____Copy of Privacy Practices requested and received.
Initial

____Copy of Privacy Practices declined.
Initial

Responsible Persons Name (Print): ____

Responsible Persons Signature: ____

Date: _________________

Witness: ____

Date: _________________

Relationship to Patient

- Self
- Parent
- Legal Guardian

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Authorization for Vest Psychiatric Services, LLC to release health information

____ ________________________
Name (Last, first, middle initial) Date of Birth

_________________________________ ______________________ _______ _______________
Street address City State ZIP Code

*I hereby authorize **Vest Psychiatric Services, LLC** to release and receive protected health information to/from:*

Name of Organization/Individual: ____

Address: ____ City: ______________________ State: ______ Zip Code:_____________

Phone Number: _________________________________ Fax Number: ___________________________________

INFORMATION TO BE DISCLOSED: (Please initial information you authorize us to receive)

___ Medical History, Examination, Reports
___ Social History
___ Academic Records
___ Entire Record
___ Psychological/Psychiatric Evaluation
___ Consultations
___ Prescriptions
___Open Communication
___ Hospital Records and Reports
___ Terminations Summary
___ Laboratory Reports
___ Treatment Plan
___ Other (Specify):____

SUCH INFORMATION WILL BE USED FOR THE PURPOSES OF: (Please initial purpose)

___ Evaluation and/or Treatment
___ Further Medical Care
___ Legal Investigation or Action
___ Follow up
___ Insurance Eligibility/Benefits
___ Changing Physicians
___ Educational Planning and Programming
___ Personal
____Coordination of Care
___ Other (Specify)____

I understand that if the person (s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouses, who must follow the federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: Right to Inspect or Copy the Health Information to Be Used or Disclosed. I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information or obtain copies of my health information by contacting Vest Psychiatric Services, LLC. **Right to Receive Copy of This Authorization-** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization**- I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization-** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact: Vest Psychiatric Services, LLC. I am aware that my withdrawal will not be effective as to uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) ____________ or until termination of care.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Vest Psychiatric Services, LLC & it's independent contractors from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (fax) copy shall have the same effect and authority as the original copy.

Signature of Patient or Legal Representative:____________________________________Date: _______________

Relationship if other than patient or a minor child:_________________________________Date: ___________________

Witness____ Date:___________________