

**Patient & Insurance Information**

Please list your Behavioral Health Coverage only. This information may be different than your major medical coverage. A copy of your card must be provided. (New Direction Psychiatric Services DOES NOT participate with Medicare or Medicaid coverage.)

Patient Name: \_\_\_\_\_ Social Security # \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Phone (Home) \_\_\_\_\_ (Cell) \_\_\_\_\_

(Work) \_\_\_\_\_ Sex: Male / Female Marital Status \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_

State \_\_\_\_\_ Zip \_\_\_\_\_ Email \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Rels. \_\_\_\_\_

If Patient is a minor:

Custodial Parent \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse or Nearest Relative**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

**Primary Mental Health Insurance**

Insurance Provider \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_

Subscriber's DOB \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Phone \_\_\_\_\_

Policy/ID # \_\_\_\_\_ Group # \_\_\_\_\_

Effective Date \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Mental Health Claims Address \_\_\_\_\_

I hereby authorize New Direction Psychiatric Services, LLC, to release medical information to authorized persons including but not limited to Primary Care Physician, referral source, insurance companies or attorney. I also authorize payment for any medical benefits be made directly to New Direction. If the patient's insurance company denies treatment as not medically necessary or if the patient has not provided the proper authorizations for initial or continued treatment, the patient acknowledges by signature below that the patient or financially responsible party will be financially responsible for services rendered.

THE UNDERSIGNED ACCEPTS FULL RESPONSIBILITY AND GUARANTEES PAYMENT FOR ALL CHARGES INCURRED BY THE ABOVE NAMED PATIENT OF NEW DIRECTION PSYCHIARTRIC SERVICES, LLC, AS AN ACCOMODATION TO PATIENT, WILL FILE INSURANCE CLAIMS. IF ANY, ON THE PATIENT'S BEHALF THE UNDERSIGNED AGREES AND GUARANTEES PAYMENT FOR ALL CHARGES INCURRED BY PATIENT WHICH ARE NOT COVERED BY INSURANCE. THE UNDERSIGNED FURTHER AGREES TO BE RESPONSIBLE FOR ALL COST OF COLLECTION, INCLUDING ATTORNEY'S FEES IN AN AMOUNT EQUAL TO TWENTY-FIVE PERCENT OF THE THEN DUE BALANCE SHOULD THIS ACCOUNT BE PLACED IN THE HANDS OF AN ATTORNEY AT LAW FOR COLLECTION. THE UNDERSIGNED UNDERSTANDS THAT NEW DIRECTION PSYCHIATRIC SERVICES, LLC, WILL CHARGE FOR APPOINTMENTS CANCELLED OR NO-SHOW WITH LESS THAN 24 HOURS NOTICE. IF INSURANCE COMPANY DENIES TREATMENT AS NOT MEDICALLY NECESSARY OR IF THE PATIENT HAS NOT PROVIDED THE PROPER AUTHORIZATIONS OR CORRECT INSURANCE INFORMATION FOR INITIAL OR CONTINUED TREATMENT, THE PATIENT ACKNOWLEDGES BY SIGNATURE BELOW THAT THE PATIENT OR FINANCIALLY RESPONSIBLE PARTY WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES RENDERED.

**I AGREE TO ACCEPT SERVICES UNDER THE ABOVE CONDITIONS**

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

## **Informed Consent for Treatment & Patient Rights and Responsibilities**

I have agreed to meet with a therapist and receive help with the problems and issues that I bring to the therapy sessions. I will make progress and benefit from this process as I work toward making changes that will create new and healthy choices in my life. As these changes occur, my therapist and I will collaborate during our sessions as well as my commitment to making efforts outside the therapy environment so as to enhance my therapeutic effectiveness.

I agree to ask any questions I may have in order to clarify the goals set for me in treatment and for my therapist to monitor my progress toward such goals. Therapy will terminate when such goals are met. I also understand that I may terminate treatment at any time I set forth. Additionally, I understand that my therapist can also terminate treatment if we do not make progress, our relationship working together does not produce results, or if I am no longer able to pay for therapy. If therapy is terminated early, my therapist will make every effort to provide other professional resources regarding my mental health care.

### **Patient's Rights**

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Only in an *emergency*, or if required by law, can records be released without member permission.
- Patients have the right to information to their treatment in a language they understand.
- Patients have the right to know all treatment choices, regardless of cost or if covered by insurance.
- Patients have the right to information about their providers.
- Patients have the right to provide input into New Direction Psych policies and services.
- Patients have the right to know about complaint, grievance and appeal processes.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to know about State and Federal laws that relate to their rights and responsibilities.

### **Patient's Responsibilities**

- Patients have the responsibility to give providers information so the provider can deliver the best care.
- Patients have the responsibility to inform the provider when they want their treatment plan changed when the plan is no longer working for them.
- Patients have the responsibility to take their medications correctly as well as to inform their providers when they are receiving medication from other providers.
- Patients have the responsibility to treat their providers with dignity and respect.
- Patients have the responsibility to keep their appointments or follow the protocol for canceling their appointments in a timely manner.
- Patients have the responsibility to inform their providers about payment problems.
- Patients have the responsibility to follow the plans and instructions for their care.

I have read and agree to comply with the above information.

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

**NOTICE OF PRIVACY PRACTICES**

In order to provide you with the best services available, it is important to inform you of the following:

Releasing any information pertaining to our patients without the patients signed release will not occur EXCEPT in the case of a court subpoena or as requested by your insurance company. We acknowledge and aim to maintain your confidentiality regarding your treatment.

At the time of your appointment, you will be expected to pay whatever is your assigned co-payment , or any amount not covered by your insurance company.

\*For prescription refills, please allow **48 hour** turnaround time after you have contacted your pharmacy for prescription refills and they fax these requests to our office.

Unless you have an *emergency*, 24 hour notice is required for cancellations or you will be charged for the missed appointment.

Please inform our receptionist of any changes in your insurance prior to your next appointment so as to prevent a denial of payment on your information going to the wrong insurance company.

Keep us up-to-date on your address and telephone number in case we need to communicate outside of your appointment times.

If you need forms filled out by your doctor, please schedule an appointment as he/she will not be able to complete these without the patient present.

**I have been offered a copy of New Direction Notice of Privacy Practices**

I have read and fully understand the above information and agree to comply with these requests.

Print Patient's Name \_\_\_\_\_

Signature of Patient/ Parent/ Legal Guardian \_\_\_\_\_

Date \_\_\_\_\_



NEW DIRECTION  
PSYCHIATRIC SERVICES, LLC

*"Growth in progress"*

Dr. Alan J. Arikian, MD  
Wanda A. Crockett, LPC  
Sarah H Nordlie, LCSW  
Nancy B. Rowe, LPC  
Dr. Mary J. Sale, PhD  
Dr. Nestor Vozza, MD

The fee schedule is as follows:

|                            |              |
|----------------------------|--------------|
| Disability Forms:          | \$25         |
| FMLA Forms:                | \$25         |
| Copies of Medical Records: | \$3 per page |
| Letters:                   | \$25-\$100   |
| Returned Check Fee:        | \$25         |

Miscellaneous fees will be based on the time required to prepare the documents requested.

Please allow 7-10 days for paperwork requests to be completed.

Reminders:

- Co-pays are due at the time of service.
- No Shows or Appointments Cancelled without 24 hours notice will result in a \$60 Service Fee.

If you have a Past Due Balance on your account and have not made payment arrangements with our Billing Department, we will not be able to schedule future appointments, process refill requests, or process document requests.

I have read and understand the above fee schedule:

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Signature of Patient/ Date

New Direction Psychiatric Services, LLC

Release of Information to Primary Care Physician

Date: \_\_\_\_\_ Patient Name: \_\_\_\_\_

To: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Care Physician's Name

\_\_\_\_\_  
Primary Care Physician's Practice

\_\_\_\_\_  
Physician's Phone

\_\_\_\_\_  
Physician's Fax

Dear Dr. : \_\_\_\_\_

In an effort to coordinate care, I want to inform you that your patient (named above) was seen by me on \_\_\_\_\_ for treatment of

\_\_\_\_\_.

Current recommendations for the type and setting of treatment include:

( ) Individual Therapy

( ) Outpatient

( ) Family Therapy

( ) Other \_\_\_\_\_

( ) Group Therapy

( ) Medication Management

If you have any questions or contributing information to share, please contact my office at (804) 423-1392.

\_\_\_\_\_  
Practitioner / Date

**New Direction Psychiatric Services, LLC**

1480 Oakbridge Court

Powhatan, VA 23139

Phone (804) 423-1392

Fax (804) 423-1393

**Release of Information**

I, \_\_\_\_\_, hereby authorize New Direction Psychiatric Services to release and/or exchange information to/from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Patient's Name \_\_\_\_\_ DOB: \_\_\_\_\_

Patient's Address \_\_\_\_\_

Phone Number \_\_\_\_\_ SS # \_\_\_\_\_

Extent of Information to be disclosed:

- ( ) Full Disclosure
- ( ) Clinical Evaluations Only
- ( ) Financial/Insurance Information Only
- ( ) Other: \_\_\_\_\_

This content is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This content will expire without express revocation on (date) \_\_\_\_\_ or (event) \_\_\_\_\_ or no longer than reasonably necessary to effectuate the purpose for which it is given.

Signature of Patient: \_\_\_\_\_

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

Signature of Parent/ Guardian (if applicable): \_\_\_\_\_

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