DeCoteau Trauma Informed-Care & Practice, PLLC

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Social Security #: _____

Address: _____

City, State, Zip: _____

Cell #: _____ Home/Work # _____

Email Address: _____

Appointment Reminder: Text _____ Phone _____ Email _____

Circle one that applies to you:

Married Single Other

Male Female Other

Other Contacts:

Emergency Contact: _____

Relationship: _____ Phone: _____

Father: _____ Phone: _____

Mother: _____ Phone: _____

Legal Custodian: _____ Phone: _____

Foster Parent: _____ Phone: _____

Other: _____ Phone: _____

Insurance Information

Insurance Company: _____

If TRICARE, you must list your Primary Care Physician (cannot be a Nurse Practitioner or Physician's Assistant).

Tricare will not pay claims without a PCP listed: _____

Policy ID Number: _____

Policy Holder's Name: _____

Policy Holder's Date of Birth: _____ Social: _____

Please provide your insurance card so a copy can be made.
Copays are due at the time of service.

Self-Pay Information

Self-pay clients must pay for services PRIOR to services rendered.
Please let DeCoteau Trauma Staff know if you are self-pay.

Authorizations and Releases

Please read and initial each item

___ -I hereby authorize the professional in charge to evaluate and administer treatment necessary or advisable

___-I have read and understand the HIPAA/Privacy Policy for DeCoteau Trauma Informed-Care & Practice, PLLC; located on the back of this form

___-I assign my insurance benefits to be paid directly to the healthcare provider

___-I authorize DeCoteau Trauma Informed Care & Practice, PLLC to release medical information required to process my insurance claim

___-I have read and understand the Billing Procedures and Policies for DeCoteau Trauma Informed-Care & Practice, PLLC; located on the back of this form

___-I authorize DeCoteau Trauma Informed-Care & Practice, PLLC to contact me by telephone, email, or text to remind me of my appointment

___-I acknowledge that I may receive a written copy of DeCoteau Trauma Informed-Care & Practice's notice of privacy practices if requested

___-I understand that this form will be part of my record until such time that I may choose to revoke the acknowledgment

___-If I am not the patient, I represent that I am authorized by law to act for and on the patient's behalf

___-If I am the client, or an individual legally obligated to pay for medical services provided to the client or guarantor of payment, I agree to pay and am financially responsible for DeCoteau Trauma Informed-Care & Practice, PLLC's established charges for all services, facilities, and supplies provided to the client

___-I understand that if no payment has been made to my account in 3 months, I will be charged an additional 10% as a late fee.

___ -I understand that if my balance reaches $600 or more, I will be put on a payment plan with payments set by DeCoteau Trauma which will pay off my balance in 6 months. Failure to sign this agreement will result in all appointments being canceled and a referral made to a different clinic.

___-I understand that in the event that my account is delinquent and assigned to a collection agency, I will also be responsible for up to 25% of the unpaid principal balance as the reasonable fee charged by a collection agency.

___-I understand that I will be charged a $50 fee for late cancellations/no-shows and providers may refer me to another facility after 3 consecutive no-shows or cancellations. I also understand that I have to pay any no-show fees prior to being seen again by my provider.

___-If I have a grievance about my provider, I understand that I am strongly encouraged to seek resolution of disputes through direct communication with the individual(s) involved before initiating the grievance process

1) If discussion with the individual(s) directly involved fails to resolve the matter, or the client is not comfortable addressing the issues with the individual(s), the client is asked to file a written grievance within 5 working days of the final discussion concerning the dispute.
2) Each grievance shall specify:
    a. The matter at issue or dispute with a clear and concise statement of the nature of the grievance including when the incident or situation leading to the grievance occurred;
    b. The remedy or solution sought;
    c. The date of the filing; and
    d. The name, title, and signature of the grievant. Any dates and results of prior discussions should also be included in the documentation. Facts not contained in the written grievance document may be introduced later in the procedure only with the consent of all interested parties.
3) Within 10 workdays of receipt of a written grievance, the director shall respond in writing, specifically to the points raised by the grievance, giving reasons for the decision(s). This procedure is intended to ensure the prompt resolution of disputes that have been addressed through informal channels, but not satisfactorily resolved.

By signing below, I acknowledge that I have read the front and back of the service agreement and authorizations and releases of DeCoteau Trauma Informed-Care & Practice, PLLC and I have agreed to the terms and conditions.

Signed: _____ Date: _____

Patient Name: _____

Patient Date of Birth: _____

CLIENT COPY

DECOTEAU TRAUMA-INFORMED CARE & PRACTICE, PLLC

515 ½ E. Broadway Ste. 106
Bismarck, ND 58501

152 N Main Street
Garrison, ND 58540

135 Sims St. Ste.208
Dickinson, ND 58601

PHONE: 701-751-0443 FAX: 701-751-1616

SERVICE AGREEMENT

BILLING PROCEDURES AND POLICIES:

DeCoteau Trauma Informed-Care & Practice, PLLC will submit your claims to your insurance provider. In order to do so, we must have a copy of your current insurance card. If you **DO NOT** have insurance, we require payment **prior** to receiving mental health services.

If you have a co-payment for mental health services, that **co-payment is due the day services are rendered.** We accept cash, credit cards, and checks for payment.

Payments are expected within 30 days after you receive your statement. Statements will be emailed to the address you provide us. If you are unable to pay your balance in full, we can discuss a payment plan. **However, if your individual balance exceeds $250.00, treatment will be suspended, and no new appointments will be scheduled until your balance is brought to good standing. If multiple family members are attending sessions at this clinic the total balance cannot exceed $1000. Treatment for all family members will be suspended if the balance exceeds this amount.** There will be a $25 charge on all returned checks.

COURT FEES: All fees related to legal proceedings will be billed to the individual patient and are not reimbursable by insurance.

PLEASE NOTE: You are required to make monthly payments or payments in full (the balance must be kept at $250.00 or less to continue services). You will be emailed monthly statements. If the balance is past due you will be notified. After 90 days with no payment or efforts to arrange payment, you will be charged a 10% late fee and may be referred to another mental health provider for services and your account will be turned over to a collection agency who will seek payment from you.

NOTE - Anyone who has a balance over $600 will be placed on a payment plan with payments set by DeCoteau Trauma that will allow for the balance to be paid off in 6 months. Failure to sign this agreement will result in all appointments being canceled and a referral made to a different clinic.

COLLECTION COSTS: I understand that in the event of any default, DeCoteau Trauma-Informed Care & Practice, PLLC may declare the entire unpaid balance to be immediately due and payable, and if DeCoteau Trauma then assigns this agreement to a collection agency for recovery, the patient will also be responsible for up to 25% of the unpaid principal balance as the reasonable fee charged by a collection agency.

NO SHOW POLICY: **Providers ask that you notify the clinic as soon as possible if you are unable to keep your appointment or if you will be late. If you are fifteen or more minutes late for your appointment it will be treated as a "no-show". After 3 cancellations and/or "no-shows" a referral to another provider may be considered. There will be a $50 fee charged directly to the patient after 3 late cancellations or "no-shows". A no-show fee must be paid prior to being seen again.**

MINOR CHILDREN:

DeCoteau Trauma-Informed Care & Practice, PLLC is not responsible for minor children left in the waiting area unattended.

TERMINATION OF SERVICES:

DeCoteau Trauma Informed -Care & Practice, PLLC will terminate services under the following circumstances:

1. When it becomes reasonably clear that the client no longer needs service, is not likely to benefit, or is being harmed by continued service.
2. If the provider is threatened or otherwise feels endangered by the client or other person with whom the client has a relationship.
3. For non-payment of services.
4. If the client's outstanding balance has been turned over to collections.
5. If the client has filed for bankruptcy and there is still an outstanding account balance.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION & ASSIGNMENT OF BENEFITS:

In addition to the release of mental health/behavioral health/chemical dependency/protected health information required by applicable law, DeCoteau Trauma-Informed Care & Practice, PLLC is authorized to release confidential mental health/behavioral health/chemical dependency/protected health information to the following individuals, entities, or agencies, but not limited to:

1. All health care providers, professionals, and/or agencies to which the patient is transferred or referred for follow-up medical care, treatment, or the primary care physician.
2. All individuals, entities, 3rd party payers, Social Security Administration (Medicare), and insurers, if any which I have disclosed and/or represented to DeCoteau Trauma-Informed Care & Practice, PLLC as being responsible for paying some or all of the charges associated with the client's care and treatment at DeCoteau Trauma-Informed Care & Practice, PLLC.

DECOTEAU TRAUMA-INFORMED
CARE & PRACTICE, PLLC
STATEMENT OF FINANCIAL UNDERSTANDING

BILLING POLICIES: As a service to our clients, DeCoteau Trauma-Informed Care & Practice, PLLC is capable and willing to assist you with filing insurance claims and answering any billing questions. All information requested is necessary for the proper processing of claims, and to speed up the billing process. Without this information, the bill will be sent directly to you.

DeCoteau Trauma-Informed Care & Practice, PLLC will not accept the responsibility for the collection of insurance claims or negotiate settlements in disputed claims. Please recognize that you, the client, are responsible for the bill. If problems arise in the processing of these claims, we will provide any assistance possible.

WORKERS' COMPENSATION: North Dakota Worker's Compensation Claims are submitted directly to the Workers Compensation Bureau by DeCoteau Trauma-Informed Care & Practice, PLLC. If the Worker's Compensation is through another state, the claim will be completed by our office and sent directly to you for submission to your individual Workers Compensation Insurance Fund.

NO-FAULT: If your visit to DeCoteau Trauma Informed-Care & Practice, PLLC is due to a motor vehicle accident, you will be asked for the name and address of the insurance company along with the claim number and date of the accident. If you cannot provide this information, the balance will be your responsibility.

PAYMENT PROCEDURES: Benefits paid directly to DeCoteau Trauma-Informed Care & Practice, PLLC are credited to your account and will be notified on the statement of any balance due.

When benefits are payable directly to you, you are responsible for submitting that payment to DeCoteau Trauma Informed-Care & Practice, PLLC. At that time, your account will be credited, and you will be notified on the net statement of any balance due.

DeCoteau Trauma Informed-Care & Practice, PLLC understands there are clients who have financial difficulties and encourages them to discuss their situation with our staff so payment arrangements can be made.

CONFIDENTIALITY:

DeCoteau Trauma-Informed Care & Practice, PLLC does everything possible to assure your confidentiality. Your limits to confidentiality may be limited by law or regulations in some situations, such as:

1. The person is a harm to him/herself or others;
2. Disclosure of suspicion of child abuse or neglect previously unreported, or
3. A court-ordered request for records

Other Considerations:

1. In the case of a minor child, DeCoteau Trauma Informed-Care & Practice, PLLC reserves the right to communicate with the client or guardian;
2. Older children, especially teens, will be allowed the same privacy as an adult; parents/guardians will be offered suggestions for enhancing their care.
3. Cellular telephones and cordless telephones are UNSECURE. It is to be understood if you choose to communicate with DeCoteau Trauma Informed-Care & Practice, PLLC using a cellular or cordless telephone we are NOT RESPONSIBLE for any overheard conversation that occurs via electronic waves/transmission.

HIPAA – Protecting Patient Privacy:

In accordance with the Health Insurance Portability and Accountability Act of 1988 (HIPAA); DeCoteau Trauma-Informed Care and Practice ensures the confidentiality, integrity, and availability of all the protected health information (PHI) it creates, receives, maintains or transmits. We care about our patient's privacy and strive to protect the confidentiality of your medical information at this practice.

DeCoteau Trauma-Informed Care and Practice is required to abide by the terms of the Notice of Privacy Practices currently in effect. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. A full copy of this notice can be provided upon request.

CONSENT FOR TELEHEALTH APPOINTMENT:

1. I understand that my healthcare provider wishes me to engage in a telehealth appointment.
2. My health care provider explained to me that the video conferencing technology will not be the same as a direct client/health care provider visit because I will not be in the same room as my provider.
3. I understand that telehealth appointments have potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology including interruptions and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth appointment if it is felt that the videoconferencing connections are not adequate for the situation.
5. I understand that while this telehealth platform is HIPAA compliant, DeCoteau Trauma is not responsible for overheard conversations that may occur at my location.
6. I have had a direct conversation with my provider or scheduler, during which I had the opportunity to ask questions regarding this telehealth appointment. My questions have been answered and the risks, benefits, and any practical alternatives have been discussed with me in a language in which I understand.