



Administrative Office
 582 Market Street, Suite 801
 San Francisco, CA 94104
 Tel 415-922-9122
 Fax 415-920-9925
 www.baywellpsych.com

PATIENT INFORMATION			
Patient Name: _____	SSN: _____	Sex: _____	
Street Address: _____		Date of Birth: _____	Marital Status: _____
City: _____	State: _____	Zip Code: _____	Email Address: _____
Cell Phone: _____	Home Phone: _____	Work Phone: _____	
Emergency Contact: _____		Phone Number: _____	
May we leave messages at: Home Phone _____ Cell Phone _____ Work Phone _____ Email _____			
GUARANTOR/PARENT/2ND PATIENT INFORMATION			
Responsible Party or 2 nd Patient Name: _____		Relationship to Patient: _____	
Date of Birth: _____		Social Security No.: _____	
Street Address: _____		Home Phone: _____	
City: _____	State: _____	Zip Code: _____	Cell Phone: _____
Employer's Name: _____		Work Phone: _____	
Business Address (if applicable): _____			
PATIENT INSURANCE INFORMATION			
1.) Primary Insurance Company Name: _____			
Subscriber ID No.: _____		Group No.: _____	
Insurance Co. Address: _____		City: _____	State: _____ Zip Code: _____
Name of Policy Holder: _____		Date of Birth: _____	
2.) Secondary Insurance Company Name: _____			
Subscriber ID No.: _____		Group No.: _____	
Insurance Co. Address: _____		City: _____	State: _____ Zip Code: _____
Name of Policy Holder: _____		Date of Birth: _____	

I hereby authorize my insurance benefits to be paid directly to Baywell Psychiatry Group. I understand that I am responsible for all charges including any added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

I hereby accept Baywell Psychiatry Group's 48-hour cancellation policy. This policy applies to business hours, as messages are not checked on weekends or holidays. I understand that my credit card will be billed for the full cancellation fee on the day after my missed appointment, unless I have made prior arrangements with my doctor.

Signature of Responsible Party: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: I hereby acknowledge that I have received and reviewed a copy of the Privacy Notice.

Signature of Patient/Parent: _____ Date: _____

PATIENT ACKNOWLEDGMENT OF CONSENT FOR TREATMENT: I hereby acknowledge that I have received and reviewed a copy of the Baywell Psychiatry Group's consent for treatment form.

Signature of Patient/Parent 1: _____ Date: _____

Signature of Patient/Parent 2 (if applicable): _____ Date: _____

CONSENT FOR TREATMENT

Welcome to our practice. This information sheet covers important issues related to your treatment. Please read it and acknowledge receipt by signing the intake form.

CONFIDENTIALITY

1. **HIPAA compliance** – Our practice safely stores your protected health information. Our electronic charting and email system are securely encrypted to maintain your confidentiality.
2. **Release of information** – Our providers must have your permission to reveal any information about you. In order to provide you with excellent medical care, we will ask for your written consent to speak with your primary care provider, therapist, family members, or others.
3. **Exceptions** – Under specific legal circumstances, information may be released without your permission. We are obligated by law to disclose information if:
 - You are an imminent danger to yourself or others.
 - You tell us about an incident of child abuse.
 - You tell us about an incident of abuse of someone over age 65 or a disabled adult.
 - You are unable to provide food, clothing, or shelter for yourself.
 - The court orders a release of information.
4. **Insurance companies** – If we are contracted with your insurance panel or you submit invoices to your insurance company, be aware that the company may request certain information from us as a requirement of your reimbursement. This information could include dates of appointments, diagnoses, medications prescribed, and treatment summaries.
5. **Emergencies** – We keep an emergency contact on record to be used only in the case of an emergency.

PROVIDER AVAILABILITY

1. **Phone calls** – Our administrative staff is available during work hours to answer your calls about scheduling or billing. If you prefer, you may leave a message on your provider's voicemail that will be returned as soon as possible. We do not charge for phone calls with your doctor of less than five minutes. Fees for longer physician calls, either with you or to coordinate care with other providers, are prorated (see fee schedule) and not covered by insurance; patients are responsible for these charges.
2. **After-hours access** – If you are having a clinically urgent situation during evenings, weekends, or holidays, you can contact your provider by following the instructions given through the voicemail system. If you are having a medical or psychiatric emergency, do not wait for a call back; call 911 or go to your nearest emergency room.

3. **Email** – Administrative staff and providers can communicate with you about non-urgent matters by our HIPAA-compliant, secure email system. When you receive an encrypted email from our group, you will be asked to create a password and sign in to read it. Please keep in mind that emails you send originating from your server may not be secure.
4. **Text** – Texting is not a secure form of communication. Our providers will not return text messages but will respond by secure email instead.
5. **Medication refill requests** – Please allow two days for refill orders to be sent to your pharmacy. In order to receive refills, you must have a future appointment scheduled.

SCHEDULING

1. **Length of sessions** – Initial assessments are 60 minutes, psychotherapy sessions are 30 to 45 minutes, and medication management appointments are 20 to 30 minutes. Our providers start and end sessions on time.
2. **Appointment reminders** – Our office sends email or phone reminders three days prior to your scheduled appointment. If you receive an appointment reminder in error, please email or call the office to clarify or cancel.
3. **Missed appointments** – We ask for two full business days' notice for any cancellations. For example, if your appointment were on Monday at 10 a.m., you would need to cancel by Thursday at 10 a.m. to avoid charges. *Please be aware that insurance companies do not cover missed sessions so cancellation fees will be charged directly to your credit card on file.* The cancellation fee is shown on the fee schedule. It is not the same as your insurance co-payment amount.
4. **Holidays and vacations** – Baywell observes holidays, and our clinicians take about three weeks of vacation each year.

FINANCIAL POLICIES – Please review and sign our Patient Financial Policies document with detailed information about fee schedules, payer policies, and other important financial details.

Please keep a copy of this for your records and sign the intake form to acknowledge receipt of this consent.

We look forward to working with you.

PATIENT FINANCIAL POLICIES

Fee Schedule – Baywell Psychiatry Group maintains a chargemaster for the practice that is updated annually on January 1st. Most fees are set at 250% of the 2021 Medicare Physician Fee Schedule adjusted for our geographic locality in Northern California. A copy of our fee schedule is attached.

Payment – Payment is collected at the time of service by cash, credit card, or check made out to Baywell Psychiatry Group. For your convenience, we keep a current credit card on file for all patients. This information is stored securely.

Private Pay – Patients without insurance or those opting to seek care outside their insurance coverage receive a 20% discount off of our fee schedule when payment is made at the time of service. These rates are found in the “Prompt Pay Rate” section of the fee schedule.

Insurance Networks – Baywell is contracted with several area insurance companies and participates in managed care programs. Copayments and deductibles are determined based on the terms of the patient’s plan. Baywell has a contractual obligation to collect copayments and deductibles from patients as defined by each managed care plan. Copayments and deductibles cannot be waived and are due at the time services are provided. If Baywell is not contracted with an insurance company, patients are responsible for submitting their claims and collecting reimbursement directly.

Telehealth – Services provided via telehealth are billed on the same fee schedule as in-person services. Any plan-required patient copayment or deductible applies for each session.

Patient Insurance Benefits – Patients are asked to call their insurance company to verify their benefits before their initial appointment. Baywell staff checks insurance benefits for all new patients; however, the information given can be unreliable and is not a guarantee of coverage. Patients are asked to present their insurance card at their first appointment.

Insurance Changes – Patients are asked to inform Baywell promptly of any insurance changes. Without timely notification, insurance companies may deny payment of visits, and patients will incur full financial responsibility.

Commercial Insurance Payer Policies – Providers are familiar with and adhere to the payer policies that guide most of the services being provided to their patients, especially medical necessity, evaluation and management visits, psychotherapy, and documentation. Meeting payer requirements is required so the practice may be reimbursed under the terms of their contracts for services provided to patients.

Medicare – For administrative and legal reasons, Baywell does not accept Medicare. If a patient is eligible for Medicare, they are asked to sign an agreement with the office stating that they will not submit invoices to Medicare.

Cancellation Policy – 48 business hours advanced notice is required to cancel or reschedule an appointment without a fee. Appointments canceled less than 48 business hours incur a no-show fee. The no-show fee is not covered by insurance and is the obligation of the patient. The no show fee must be paid before the next appointment. If staff are able to fill the appointment time, the no show fee will be waived.

Here is a list of the no show fees:

<i>Visit Type</i>	<i>Physician</i>	<i>Psychologist</i>
Initial Diagnostic Evaluation, 60 minutes	\$425	\$315
Psychotherapy Session, 45+ minutes	\$200	\$100
Medication Management, 30+ minutes	\$175	n/a

Statements – Statements will be provided upon patient request.

Initial Assessments – For adults, initial assessments may take up to three one-hour visits to complete. For children and teenagers, initial assessments may take up to four one-hour visits to complete. Additional charges for medical record reviews and collateral phone calls may be required to complete the assessment.

Couples Therapy – Couples therapy sessions are billed as private pay rates. Both parties in a couple are equal participants in the treatment and both are legal holders of privilege to records or release of information.

Financial Hardship – In the event of financial hardship, patients may apply for a sliding scale fee schedule. A separate application is required and the request may be granted for 3 months.

Payment Plans – In the event of financial hardship, patients may apply for a payment plan. Should payment plans lasting longer than 3 months be required, the patient may be referred to Care Credit or similar health care credit program.

Community Service – As a service to our community, providers support area non-profit organizations through the provision of pro-bono or sliding scale services to specific programs.

By signing this form, I certify:

- I have received a copy of Baywell’s fee schedule.
- I have read and understand Baywell’s financial policies.

Patient or Guardian Signature

Date



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582 Market Street, Suite 812
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CREDIT CARD AUTHORIZATION

Patient Name _____

Baywell Psychiatry Group keeps credit cards on file for all patients. This information is stored securely in your electronic chart in accordance with PCI standards. Your credit card will be billed for all charges on the next business day, unless the account is paid by check or cash. This form is to be completed by patient or guardian.

I, _____, hereby authorize Baywell Psychiatry Group to charge my credit card to pay for my sessions and any other charges I incur at Baywell Psychiatry Group. I affirm that I am at least 18 years old and that I am legally authorized to use the credit card account number specified below. I understand that I will be charged for the full amount. I will not dispute sessions that I have received or that I have not cancelled less the 48 hours in advance. I authorize Baywell Psychiatry Group to accept updated account information verbally.

If the information below changes, I will let Baywell Psychiatry Group know immediately.

Card Type (please choose) Visa MasterCard Discover FSA HSA

Card Number _____

Expiration ____ / ____ Security Code _____

Name (as it appears on the card): _____

Cardholder Billing Address: _____

Signature of Cardholder

Date

Printed Name of Cardholder

Notice of Privacy Practices

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.

WHO WILL FOLLOW THIS NOTICE

This Notice of Privacy Practices (the "Notice") describes Baywell Psychiatry Group's practices and those of Baywell personnel who are involved in your care. Baywell and these individuals will follow the terms of this Notice, and may use or disclose medical information about you to carry out treatment, payment or health care operations, or for other purposes as permitted or required by law. This Notice describes your rights to access and control medical information about you, including information that may identify you and that relates to your past, present, or future physical, medical, or mental condition and medical care and related health care services. Other healthcare providers with whom you interact may have their own Notices of Privacy Practices.

BAYWELL'S PLEDGE REGARDING MEDICAL INFORMATION

Baywell understands that medical information about you and your health is personal. Baywell is committed to protecting medical information about you. In order to provide you with quality service and to comply with certain state and federal legal requirements, Baywell creates a record of the services you receive at Baywell. This Notice applies to all of the records of your care generated by Baywell. This Notice will tell you about the ways in which Baywell may use and disclose medical information about you. It also describes your rights and certain obligations Baywell has regarding the use and disclosure of medical information. Baywell is required by law to: (1) Make sure that medical information that identifies you is kept private; (2) Give you this Notice of its legal duties and privacy practices concerning medical information about you; (3) Follow the terms of the Notice that are currently in effect; and (4) Notify you in case there is an unauthorized use or disclosure of your unsecured medical information.

HOW BAYWELL MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that Baywell may use or disclose protected medical information. For each category of uses and disclosures, Baywell will explain what is meant and may give some examples. Not every use or disclosure in a category will be listed. However, all of the ways Baywell is permitted to use and disclose information will fall within one of the categories. Some information such as Psychotherapy Notes, certain drug and alcohol information, HIV, or mental health information is entitled to special restrictions.

For Treatment. Baywell may use medical information about you to provide you with medical treatment and to coordinate or manage your medical treatment and any related services. We may disclose information about you to Baywell workforce members or other providers involved in your treatment. We may also disclose your medical information to family members or other individuals involved in your continuing medical care with your consent.

For Payment. Baywell may use and disclose medical information about you so that Baywell can get paid for the treatment and services provided by Baywell. For example, Baywell may need to give information to your health plan, Medi-Cal, or Medicare about treatment you receive from Baywell

so that they will pay Baywell or reimburse you for your care. Baywell may also tell your health plan about a proposed treatment to determine whether your plan will cover the treatment.

For Health Care Operations. Baywell may use and disclose medical information about you to carry out activities that are necessary for Baywell operations. These uses or disclosures are made for quality of care, compliance activities, administrative purposes, contractual obligations, grievances or lawsuits. For example, Baywell may use medical information to review treatment and services provided at Baywell or to evaluate the performance of its staff in caring for you.

To Individuals or Family Members Involved in Your Health Care. Unless you object, Baywell may disclose medical information about you to a member of your family, a relative, close friend or any other person that you identify who is involved in your care. Baywell may also tell your family or friends, personal representative, or any other person who is responsible for your care, of your location, general condition or death, unless you object.

Emergencies. Baywell may disclose medical information about you to a public or private entity assisting in disaster relief so that your family can be notified about your condition, status, or location. You may object to this disclosure with a written request. However, if you are not available or are unable to agree or object, or in some emergency circumstances, Baywell will use its professional judgment to decide whether this disclosure is in your best interest.

If you would like to object to this disclosure, check here.

For Fundraising Activities. Baywell may use medical information about you to contact you about Baywell sponsored activities including fundraising events. We will only use contact information such as your name, address, and phone number. You may opt out of receiving such communications.

If you would like to opt out of such communications, check here.

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

Workers' Compensation. Baywell may release medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

For Public Health Activities. Baywell may disclose medical information about you for public health activities. These purposes generally include the following: (1) To prevent or control disease, injury, or disability; (2) To report deaths; (3) To report abuse or neglect of children, elders, and dependent adults; (4) To report reactions to medications or problems with products; (5) To notify people of recalls of products they may be using; and (6) To notify a person who may have been exposed to a disease or who may be at risk for contracting or spreading a disease or condition.

For Health Oversight Activities. Baywell may disclose medical information about you to a health oversight agency for activities authorized by law.

For Lawsuits and Disputes. Baywell may disclose medical information to courts, attorneys, and court employees in the course of conservatorship and other judicial or administrative proceedings. Baywell may disclose medical information about you in response to a court or administrative order, subpoena, discovery request, or other lawful process.

Disclosure to Law Enforcement. If asked to do so by law enforcement and as authorized or required by law, Baywell may release medical information: (1) To identify or locate a suspect, fugitive, material witness, or missing person; (2) About a suspected victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement; (3) About a death suspected to be the result of criminal conduct; (4) About criminal conduct on Baywell's premises;

and (5) In case of a medical emergency, to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

To Coroners, Medical Examiners and Funeral Directors. Baywell may release medical information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. Baywell may also release medical information about you to funeral directors.

For Specialized Government Functions. Baywell may disclose medical information about you to authorized federal officials for intelligence, counter intelligence, and other national security activities. Baywell may release medical information about you to authorized federal officials so that they may conduct special investigations or provide protection to the President, or other authorized persons or foreign heads of state, as authorized by law.

Information About Inmates/Individuals in Custody. If you are an inmate or under the custody of a law enforcement official, Baywell may release medical information about you to the correctional institution or law enforcement official responsible for you as authorized or required by law.

Disclosure For Threats to Health and Safety. In certain circumstances, Baywell may be required to disclose medical information to avert a serious threat to your health and safety or the health and safety of another person as required by law enforcement. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

SPECIAL PROVISIONS RELATED TO PRIVACY

Psychotherapy Notes. Baywell will not release any Psychotherapy Notes without a specific authorization from you that allows Baywell to release the notes. Psychotherapy notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished and any summaries of diagnosis, functional status, treatment plan, symptoms, prognosis and progress to date.

Substance Abuse. Baywell will not disclose identity and records of your diagnosis, prognosis or treatment that are maintained in connection with performing any drug abuse treatment or prevention efforts without your written consent.

HIV/AIDS. Baywell will not disclose the results of an HIV/AIDS test unless you give Baywell specific written authorization. Baywell may disclose HIV/AIDS test results without your specific authorization as required by state or federal reporting laws.

YOUR RIGHTS

Your medical information is the property of Baywell. However, you have the following rights regarding your medical information.

Right to Inspect and Copy. With certain exceptions, you have the right to inspect and receive copies of your medical information that is in the records of Baywell. To inspect and receive a copy of your medical information, you must submit your request in writing to:

Baywell Psychiatry Group
Attn: HIPAA Privacy Officer
582 Market Street, Suite 812
San Francisco, CA 94104
Fax: (415) 920-9925

If you request a copy of your medical information, Baywell may charge a fee for the costs of copying and mailing. Baywell may deny your request to inspect or copy your medical information in certain circumstances. If you are denied access, you may request that the denial be reviewed. Another licensed health care professional at Baywell who was not involved in the initial denial will review the decision. Baywell will comply with the outcome of the review.

Amendment. If you feel that medical information about you is incorrect or incomplete, you may ask Baywell to amend the information. You have the right to request an amendment for as long as Baywell keeps your medical information. To request an amendment of your medical information, you must submit your request in writing to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104. In addition, you must provide a reason that supports your request. Baywell may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, Baywell may deny your request if you ask to amend medical information about you that was not created by Baywell, is not part of the medical information about you kept by Baywell, is not part of the medical information about you that you would be permitted to inspect and copy, or is accurate and complete.

Addendum. You have the right to submit an addendum to your medical information maintained by Baywell. The addendum must be made in writing and submitted to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104.

Right to an Accounting of Disclosures. You have the right to receive a list of certain disclosures that we have made of your medical information. To request this accounting of disclosures, you must submit your request in writing to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104. Your request must state a time period that may not be longer than ten (10) years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional accountings, Baywell may charge you for the costs of providing the list. Baywell will notify you of the costs involved, and you may choose to withdraw or modify your request at that time before any costs are incurred. In addition, Baywell will notify you, as required by law, if your medical information is unlawfully accessed or disclosed or accessed by an unauthorized person or if there is a breach of Baywell's security system that affects your protected health information.

Right to Request Restrictions. You have the right to request a restriction or limitation on medical information that Baywell uses or discloses about you for treatment, payment or health care operations, and to request a limit on the medical information that Baywell may disclose to family members or friends involved in your care. To request a restriction, you must submit your request in writing to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104. In your request, you must tell Baywell: (1) What information you want to limit; (2) Whether you want to limit Baywell's use, disclosure, or both; and (3) To whom you want the limits to apply (for example, disclosures to your spouse). Baywell is not required to agree to your request. If we agree, our agreement must be in writing.

Request Confidential Communications. You have the right to request that Baywell communicate with you about your appointments or other matters related to your treatment in a specific way or at a specific location. To request confidential communications, you must submit your request in writing to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104. Baywell will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

CHANGES TO THIS NOTICE

Baywell reserves the right to change the terms of this Notice at any time. Baywell reserves the right to make the revised or changed notice effective for medical information Baywell already has about you as well as any information Baywell receives in the future. Baywell will post a copy of the current Notice in its physical facility and on its website. The Notice will contain an effective date.

QUESTIONS AND COMPLAINTS

If you have any questions or believe that your privacy rights have been violated, you may contact Baywell's HIPAA Privacy Officer in person or mail a written summary of your concern to: Baywell Psychiatry Group, Attn: HIPAA Privacy Officer, 582 Market Street, Suite 812, San Francisco, CA 94104.

You may file a written complaint with the Department of Health and Human Services at the following address: Office of Civil Rights, DHHS, 90 7th Street, Suite 4-100, San Francisco, CA 94103. Phone: 800-368-1019. Fax: 202-619-3818. Email: ocrmail@hhs.gov. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this Notice or the laws that apply to use will be made only with your written permission. If you provide Baywell permission to use or disclose medical information about you, you may revoke that permission in writing at any time. If you revoke your permission, Baywell will stop any further use or disclosure of your medical information for the purposes covered by your written authorization, except if Baywell has already acted in reliance on your permission. You understand that Baywell is unable to take back any disclosure Baywell has already made with your permission and that Baywell is required to retain its records of the care that Baywell provided to you.

ACKNOWLEDGMENT OF RECEIPT

By signing this form, you acknowledge that you have received the Notice of Privacy Practices of Baywell.

Signature of Patient 1: _____ Date: _____

Print Name: _____

Signature for Patient 2: _____ Date: _____

Print Name: _____

If signed by someone other than the individual to whom the health information pertains, state the name, relationship, and authority to sign the authorization on the individual's behalf, and attach any supporting documentation to this request:

Name: _____ Relationship: _____