ROCHESTER CENTER
FOR BEHAVIORAL MEDICINE

Welcome to the Rochester Center for Behavioral Medicine. We are pleased that you have chosen to receive treatment at our clinic. It is our goal to help expedite your treatment goals as smoothly as possible. For this reason, there are several policies of which you should become aware. Please review the following:

Prescription Policies:
You may obtain prescription refills from your prescribing clinician during your scheduled appointments. If your prescriptions will run out before your next appointment, you may submit our online refill request form, which can be found on our website (www.rcbm.net) under "Prescription Refills." Please note that medication changes can only be made by your prescriber, not by RCBM office staff.

Be sure to allow 2 BUSINESS DAYS for your prescription to be processed. Please be aware that the prescription request system is not checked over the weekend, so requests submitted from Friday afternoon through Sunday night may not be received until Monday morning.

We are now able to e-scribe controlled substance prescriptions to *most* pharmacies. This newer (2015) functionality is a safer and more efficient way to prescribe these medications. If your pharmacy does not participate in this program, we may ask you to select a pharmacy that does. Please allow us time to transmit your prescriptions to your pharmacy after your appointment.

Some insurance companies may require a prior authorization before certain prescriptions can be filled. This process often takes up to an hour of administrative time. Please note that, if a prior authorization is needed, you may need to wait one to three days for your prescription to be authorized by your insurance company.

Medications prescribed by RCBM are expected to be taken only as prescribed, and only by the patient to whom they were issued. Any misuse or diversion of medications may result in termination of care.

Appointment Duration and Frequency:
Once you are doing well on your medication regimen, your medication management visits may become less frequent. However, the maximum time between appointments cannot exceed four months unless your clinician has made a special exception for you. Further, three-month prescriptions cannot be processed until outstanding balances have been addressed.

The frequency of therapy visits varies based on acuity of the patient's presenting concerns. Therapy visits are generally 45-50 minutes in length. Medication reviews and supportive therapy typically last around 15-20 minutes. Therapy visits longer than 53 minutes are considered 'extended visits' and may be billed at a proportionate rate.

Cancellation Policy:
We ask that you provide at least 24 hours of notice if you need to cancel your appointment (48 hours for testing appointments), as we often have a wait list that we try to accommodate. A message may be left if you call before or after business hours. If you do not give the required notice on a missed appointment, you are subject to a charge that is the full amount of your visit. Please let your clinician know if there has been an emergency. This missed appointment fee cannot be billed to your insurance company.

Reminder Calls/ Phone Tree:
Appointment reminders are made the business day before your appointment. Our reminder system allows you to receive a reminder by any combination of e-mail, text, or phone call. You may use this system to confirm appointments but cancellations must be made by calling our office directly. You are able to opt out of any of these automated reminder methods at any time. Be sure you have provided the front office staff with any changes in your contact information to ensure that you receive these reminders. Please be aware that reminder calls are offered as a *courtesy* and are not guaranteed. The patient remains responsible for keeping track of your appointment date and time.

Updating Information:
Please be sure to notify us of any changes to your contact information, including the best phone number to use for reminder calls. Also remember to give us your updated insurance card should your policy change. If an up-to-date insurance card is not provided, you will be responsible for out-of-pocket payment for the visit.

Electronic Medical Record:
The Rochester Center for Behavioral Medicine utilizes an Electronic Medical Record. All information contained in your record is securely stored and remotely backed up, and all Electronic Protected Health Information (ePHI) policies are carefully observed.
You may notice your clinician typing throughout your visit. This allows our staff to accurately capture the information you are presenting.

HIPAA Information:
RCBM takes privacy very seriously. We require all employees to complete a formal HIPAA training course and pass a certification exam. RCBM staff exercises absolute discretion when conducting transactions involving the exchange of protected health information (PHI). We will not release any PHI to an outside source unless we have obtained the patient's (or patient's legal guardian's) written consent. If you need any information released, your clinician or our front office staff would be happy to provide you with the appropriate forms. The forms can also be located on our website. Please note that, upon the request of your referring physician's office, we may release information required to coordinate your care, as allowed by HIPAA.

Medical Record Requests:
Should you wish, we are happy to release information to other medical professionals. To make a medical records request, please call extension 259. Once the request has been made and a release has been signed, it may take up to two weeks to process your request. Depending on the nature of your request, you may incur a fee for this service. Please be aware that progress

notes are kept for internal use. Therefore, it is up to the discretion of the clinician to decide whether records will be released directly to the patient.

Payment:
Please be prepared to pay your co-pay or session fee at the time of service. You are responsible for your insurance company's "allowed amount" for each visit until your deductible has been met. Payment is expected on the date of service even when the responsible party is not present for the visit.

RCBM accept checks, cash, Visa, MasterCard and American Express. If you cannot make a payment on the date of service, please contact our biller, Brenda, at (248) 851-0526 to make payment arrangements. Should you wish, we are able to leave a credit card on file. Individuals who default on established payment plans without contacting our billing office, or individuals who do not return phone calls related to billing issues, may be asked to seek care elsewhere.

Insurance Questions:
We understand that insurance issues can be difficult to navigate. Terms such as deductible, co-insurance, co-pay, and out-of-pocket-maximum, may not be universally understood. If you have any questions about general insurance terms or need help understanding your specific coverage, please feel free to contact our insurance liaison, Ali, at (248) 608-8800.

Mid-Level Providers:
The Rochester Center employs physician assistants and psychiatric nurse practitioners (often referred to as mid-level providers or physician extenders). These professionals are experienced, independently licensed behavioral health providers. They are able to prescribe medications and practice under the close supervision of Joel L. Young, M.D., Medical Director. Patients may be directly assigned to the care of these providers or may see a mid-level provider if Dr. Young becomes unexpectedly unavailable.

Useful Information:
RCBM is active on social media. Please follow us on Facebook (RCBM) and Twitter (@RochesterCenter) to stay abreast of mental health news, topics of interest, and clinic news and updates. We also update our website (www.rcbm.net) regularly. Finally, Dr. Young's blog on PsychologyToday.com (When Your Adult Child Breaks Your Heart) is an excellent source of information on all topics related to mental health.

Please feel free to speak with our front office staff if you need clarification on any of the information listed above. Thank you for your cooperation. We look forward to working with you!

I have read the above-listed policies and agree to abide by them. I understand that any violation of these policies may result in the termination of my care.

_____ _____

Patient/Guardian Signature *Date*

ROCHESTER CENTER FOR BEHAVIORAL MEDICINE (RCBM)
DOCUMENTATION OF GOOD FAITH EFFORT / ACKNOWLEDGEMENT OF THE HIPAA PRIVACY NOTICE

Patient Name (please print): _____

Patient Signature: _____ Date: _____

The patient presented for treatment on this date and was provided with a copy of the practice's Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:

_____

_____

☐ There was a medical emergency. (The practice will attempt to obtain acknowledgement at the next available opportunity.)

☐ Other reason, as described below:

_____

_____

_____

_____

_____

Signature of employee completing form:_____

Payment Policy

Thank you for choosing the Rochester Center for Behavioral Medicine. We are committed to providing you with the best in quality health care. We have outlined our payment policies for you below. Please read carefully and feel free to ask us any questions you may have. A copy will be provided to you upon request.

1. Insurance. We participate with many insurance plans. If you are insured by a plan with which we do not participate, payment in full is expected at each visit. If you are insured by a plan with which we DO participate with but have not presented us with an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have. By signing you are authorizing RCBM to release required information to your insurance company.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Non-payment at the time of service may result in a service charge.

3. Non-covered services. Please be aware that some – perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by your insurer. You must pay for these services in full at the time of visit.

4. Proof of Insurance. We must obtain a copy of your driver's license and current valid insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

5. Claims submission. We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

6. Coverage changes. If your insurance coverage changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

7. Nonpayment. Please be aware that if a balance remains unpaid for more than 90 days, we may refer your account to a collection agency and you and your immediate family members will be discharged from this practice.

8. Missed appointments. If you must cancel an appointment, we ask that you give the office at least 24 hours notice, 48 hours notice is required for screening/testing appointments. Otherwise, you may be charged the full session fee, without insurance reflecting. This charge will be your responsibility and cannot be billed to insurance.

9. Divorce/Separation. In situations of divorce or separation, the person bringing the minor child to treatment will be responsible for payment on the date of service. If the divorce decree requires that other (non-present) parent to pay all or part of the treatment cost, it is the present parent's responsibility to collect from the other parent. For adults, the person seeking treatment is the person responsible for payment.

Our practice is committed to providing the best treatment to our patients. Our fees are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

***I have read and understand the payment policy and agree to abide by its guidelines**:*

_____ _____

Signature of patient or responsible party **Date**

_____

Please print name of person signed above

10/7/2016

ROCHESTER CENTER FOR BEHAVIORAL MEDICINE

CONFIDENTIAL CHILD HISTORY

Patient's Name:_____ ☐ Male ☐ Female Date of Appointment: _____

Age:_____ Current Address:_____

Place of Birth_____Parent/Guardian Names: _____ ☐ Natural ☐ Adopted

Please explain why you are seeking professional help for your child:

_____
_____
_____
_____
_____

CHILD'S ACADEMIC HISTORY—

Name of School and District:

Elementary School: _____
Middle School: _____
High School:_____
College School:_____

NOTES:

_____
_____
_____
_____

Does your child currently receive/has your child ever received special services in school? ☐ Yes ☐ No
If yes, please explain:

_____
_____

Has your child ever experienced any academic or behavioral difficulties? ☐ Yes ☐ No
If yes, explain:_____

Has your child ever been in trouble with the law? ☐ Yes ☐ No
If yes, please explain: _____
_____

Has your child ever threatened to physically harm someone? ☐ Yes ☐ No
If yes, please explain:

_____
_____

HEALTH HISTORY:

MEDICAL PROBLEMS: ☐ Yes ☐ No

Past	Present
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES: ☐ Yes ☐ No

Please list Allergies	Reaction
_____	_____
_____	_____
_____	_____
_____	_____

FOR FEMALES:

At what age did patient begin menstruating?: _____ ☐ Not Applicable
(If patient is menstruating), does patient display any mood problems during menses? ☐ Yes ☐ No
If YES, please explain: _____
_____

SURGICAL HISTORY: ☐ NONE

Surgery/Procedure:	Date (Approximately):

Please list all prior mental health and alcohol/substance abuse counseling or treatments the patient has received:
☐ NONE
OR
Where:_____ When:_____
Where:_____ When:_____
Where:_____ When:_____

PERINATAL AND DEVELOPMENTAL HISTORY:
Number of pregnancies prior to this child: _____
Number of live births prior to this child: _____
Number of miscarriages/stillbirths prior to this child: _____
Age at time of child's conception: _____

Yes	No	Unknown	
☐	☐	☐	Full-term pregnancy?
☐	☐	☐	Medications for the mother? If yes, please specify:
☐	☐	☐	Bleeding/Spotting?
☐	☐	☐	Persistent vomiting?
☐	☐	☐	Eclampsia/pre-eclampsia/high blood pressure/swelling/urine protein?
☐	☐	☐	Drugs or other toxic substances to which mother was exposed? If yes, specify:
☐	☐	☐	Other illnesses? If yes, specify:
			Maternal weight gain: _____ pounds
☐	☐	☐	Vagina delivery?
☐	☐	☐	C-section?
☐	☐	☐	Forceps used?
☐	☐	☐	Breech Presentation?
☐	☐	☐	Fetal bradycardia (slow heartbeat)?
			Birth weight of child?: _____ lbs _____oz
☐	☐	☐	Jaundiced?
☐	☐	☐	Transfusion(s) required?
☐	☐	☐	Other after-birth medical problems?
☐	☐	☐	Was baby born with any congenital problems?
☐	☐	☐	Was the child discharged from the hospital within 3 days of birth?
☐	☐	☐	Bottle-fed?
☐	☐	☐	Breast-fed? To what age? _____
☐	☐	☐	Slept well?
☐	☐	☐	Fretful?
☐	☐	☐	Bonded well?
			How would you describe your baby's temperament? _____
			Age at walking unassisted: _____
			Age baby spoke first words: _____
			Age baby put two or three words together: _____
			Age at toilet training: _____

SLEEPING DIFFICULTIES ☐ NONE Additional information:

☐ Difficulty with daily functioning	
☐ Falling asleep	
☐ Falling back to sleep	
☐ Tired upon waking	
☐ Early morning awakening	
☐ Bad dreams	
☐ Nightmares	
☐ Wetting the bed	
☐ Walking in sleep	
☐ Snoring	
☐ Stop breathing during sleep	
☐ Falling asleep when emotional	

SUICIDAL ISSUES/ SELF-HARM HISTORY:

Does your child have a history of suicide attempts? ☐ Yes ☐ No

If "yes," please explain "when" and "how":

_____

_____

_____

Has your child ever intentionally harmed himself/herself? ☐ Yes ☐ No

If "yes," please explain: _____

_____

_____

MEDICATION/PHARMACY INFORMATION:

Pharmacy (LOCAL) Name: _____

City:_____ Phone Number: _____

Pharmacy (MAIL ORDER) Name: _____

Phone Number: _____

Current Psychiatric Medications: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful, 5=Very Helpful

Past Psychiatric Medications: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful, 5=Very Helpful

Current NON-PSYCHIATRIC Medications / Vitamins / Supplements: ☐ **NONE**

Name of Medication	Strength (i.e. 50mg)	Frequency (i.e. once daily)	Duration (i.e. 1 month)	How Helpful (0-5)? 0=Unhelpful, 5=Very Helpful

SUBSTANCE USE HISTORY:

CAFFEINE (if any) – Cups per Day Is your child sensitive to caffeine? ☐ Yes ☐ No ☐ N/A

NONE: ☐
Coffee: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐
Tea: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐
Soda: 1 ☐ 2 ☐ 3 ☐ 4 ☐ More ☐

SMOKING STATUS:

Please check below the response that best summarizes your child's CIGARETTE smoking status and answer any questions corresponding to that response. Please note that 1 pack = 20 cigarettes.

☐ **Never** smoked.

☐ **Former** smoker: (*average* number of cigarettes patient used to smoke per day):
☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ 2 packs
☐ Other (include approximate amount patient used to smoke per day):_____

☐ **Current** smoker: (*average* number of cigarettes your child currently smokes per day):
☐ ¼ pack ☐ ½ pack ☐ 1 pack ☐ 2 packs
☐ Other (include approximate amount patient used to smoke per day):_____

Total number of years that patient has smoked, these years do not need to be consecutive: _____

FAMILY HISTORY

Parents Marital Status:
☐ Patient's Biological/Adoptive Parents are married to each other
☐ Patient's Biological/Adoptive Parents are divorced from each other (If yes, please complete the next question):
Mother: ☐ Single ☐ Remarried ☐ Significant Relationship ☐ Other: _____
Father: ☐ Single ☐ Remarried ☐ Significant Relationship ☐ Other: _____
Mother's Job/Profession: _____
Father's Job/Profession: _____

Family Members	**Living "L"**	**Deceased "D"**	**Lives with patient? "Yes" or "No"**	**Age**	**Quality of the Relationship with Patient**
Mother:					
Father:					
Step-Mother:					
Step-Father:					
Siblings:					
Grandparents:					
Others (Specify):					

FAMILY PSYCHIATRIC / SUBSTANCE ABUSE HISTORY:

Diagnosis/Suspected Diagnosis and whether Treated/Untreated:	**Relation** (*please indicate maternal or paternal if applicable*):

CHILD'S SOCIAL HISTORY:

Has your child ever been bullied? ☐ Yes ☐ No

Has your child ever been accused of being a bully? ☐ Yes ☐ No

If you answered "yes" for either of the above questions, please explain:

_____

_____

Social/Leisure Activities / Hobbies / Sports (please list and/or describe):

_____ _____

_____ _____

_____ _____