innerQuest Psychiatry & Counseling
932 Hendersonville Road, Suite 104
Asheville, North Carolina 28803
(828) 333-5240 Phone
(828) 274-7787 FAX

NEW PATIENT REGISTRATION PACKET

Welcome. The material enclosed in this packet introduces you to innerQuest Psychiatry & Counseling. The providers and staff of innerQuest strive to create a comfortable environment for our patients. We ask that you review the enclosed material and complete the forms and bring them with you to your first appointment.

Arrival time
Please arrive 15 minutes prior to your first appointment so that our staff may complete your patient registration. We require all patients to enroll in our Patient Portal. This feature of our Electronic Health Record permits you to access to certain portions of your record, obtain reminders of upcoming appointments, and it provides a means to communicate with us in a secure manner for non-urgent issues and refill request.

What to bring
Please bring the following items with you to your first appointment:

- Insurance card(s)
- Photo ID (Example: driver's license, passport, military ID)
- Completed registration forms.

It is your responsibility to verify your coverage for services with the attached *Benefits Confirmation Form.* This will better help you in determining the amount of your deductible, your required copayment, any limits concerning the number of mental health visits your insurance allows. You must bring the completed Benefits Confirmation Form so that our staff may verify your benefits.

Payment
Payment is expected at the time of service. If our staff is unable to verify your benefits or confirm the amount of your co-payment and deductibles you will be required to pay the full amount of the visit.

Confidentiality
Within certain limits, information revealed by you during therapy will be kept strictly confidential and will not be revealed to any other person or agency without your written permission. At times therapy may involve the participation of more than one family member and/or significant person(s). While your provider will attempt to follow your wishes, they do not guarantee confidentiality among participants in the family or couples therapy.
There are certain situations in which your provider is required by law to reveal information obtained during therapy to other persons or agencies without your permission. These would include:
a) If you threaten bodily harm or death to another person, your provider is required by law to inform the intended victim(s) and appropriate law enforcement agencies.
b) If you threaten bodily harm or death to yourself, your provider will inform law enforcement agencies and others (such as your spouse, friends or inpatient psychiatric institution) who could aid in prohibiting you from carrying out this threat.
c) If you reveal information related to the abuse or neglect of a child, dependent adult or elderly person, your Provider is required by law to report this to the appropriate authorities.

NOTE: Those seeking Couples or Family Therapy should review and sign the "No Secrets" Policy Confidentiality included in the New Patient Registration Packet.

Contact Information:
You may reach our office at (828) 333-5240 and our FAX is (828) 274-7787. If you wish to leave a message for your provider call our office number and select the appropriate voice mailbox from the menu. If you are experiencing a clinical emergency please call 911 or proceed to the nearest emergency room. Our answering service is available for established 24 hours a day, seven days a week to handle after-hours calls and can be reached at (828) 650-8436.

Please note that because email is not 100% private, email communications should not be used for emergencies or clinical correspondence.(This does not include secure communications using our Patient Portal.)

Office Hours: Our office hours are 8:00 AM until 5:00 PM, Monday - Thursday and Fridays by appointment only.

Forms Enclosed:

Benefits Confirmation Form
Patient Registration Form
Confidential Communications Form
Notice of Privacy Practices Acknowledgement
Financial Policy
Instructions
Supplemental Medical History

If you have any questions about any of the forms, please do not hesitate to call us at (828) 333-5240. Thank you for choosing innerQuest Psychiatry & Counseling. We look forward to serving you.

Sincerely,

Shevell Martin

Practice Manager
innerQuestpsychiatry@gmail.com

innerQuest Psychiatry & Counseling, PLLC
932 Hendersonville Road #104
Asheville, North Carolina 28803
www.innerQuestNC.com
Phone: (828) 333-5240 / Fax: (828) 274-7787
Email: innerquestpsychiatry@gmail.com

Leonard L. Cruz. MD, ME
Steven D. Buser, MD
Samuel Thielman, MD PhD

Richard Smoot, PsyD
Megan Reilly Buser, LCSW

BENEFIT CONFIRMATION FORM

Name: (of Patient):	Insurance Company:
ID#:	Group#:

Please have your insurance card in hand

THIS FORM MUST BE COMPLETED PRIOR TO APPOINTMENT OR THE FULL AMOUNT OF YOUR VISIT WILL BE EXPECTED IN FULL

WHEN YOU CALL YOUR INSURANCE COMPANY ASK THE FOLLOWING QUESTIONS:

"This is (YOUR NAME) and I am calling to get details about my behavioral health benefits."

1. Do I have a co-pay or co-insurance for OUTPATIENT Behavioral Health? _____
2. What is the amount I pay per visit? $_____
3. What is my deductible? $_____
4. How much of my deductible has already been met? $ _____ As of Date: _____
5. When does my deductible period start? (Date each year)_____
6. What is the effective date of my insurance policy? (Month/Day/Year)_____
7. How many visits does my policy allow for OUTPATIENT Behavioral Health Per year?
8. If I need more outpatient visits what do I do to obtain authorization?
9. Is there a yearly maximum for OUTPATIENT Behavioral Health?_____
   (Inpatient Maximum if applicable?) _____
10. Do I need an authorization for my visits?_____
11. How do I obtain an authorization? _____
12. Where and who should my provider mail claims to?_____
13. What is your EDI Payer number? _____
14. May I please have your name, your extension number and the Reference# for this call?
    Name:_____ Ext:_____ Reference #:_____

Name: (Person Making Call) _____ Date of Call: _____
Time of Call:_____ Phone Number called_____

NOTE: Benefits Confirmation Form should be received by innerQuest Psychiatry & Counseling prior to your first session in order for the office to verify your benefit. This allows our staff to calculate the payment you will be expected to make at the time of service. If this information is not received prior to your visit you will be responsible for the full fee amount until your benefits are verified or this completed form is received. Thank you.

Signature of Patient: _____
Date: _____

Cancellation policy

If for any reason you are unable to attend your scheduled appointment you must call a minimum of 24-hours in advance *(48* hours is preferred) or you will be charged between $100 - $150 fee. Charges arising from late cancellations or missed appointments without notice are not reimbursed by your insurance carrier, and will not be submitted to your insurer.

Returned checks

If your personal check is returned for insufficient funds, you will be charged a fee of $45.00.

Insurance Benefits

innerQuest is pleased to assist you by filing insurance on your behalf. An insurance policy is a contract between you and your insurance company. All deductibles, co-pays, and amounts not covered by your policy are your responsibility and you are asked to keep your account current at each visit. Our providers are participating providers with several insurance plans. However, you are ultimately responsible for payment of all services rendered, including those that are not covered by insurance.

Fees and Unpaid Balances: The fee for your first appointment schedule will be discussed with you at your initial consultation or prior to your appointment if you wish. After the first visit, charges vary based on the complexity, duration, and treatment rendered during your visit. Physician providers (Psychiatrists) bill services in a manner similar to other physicians-that is a charge for an office visit typically combined with a separate charge for psychotherapy. Telephone and written communications with your provider may be subject to charges based on the duration of the service. Fees for Psychological Testing, Genetic Testing, and certain Consultations to coordinate care will be charged as separate services. We ask that you keep your account. Outstanding balances that remain unpaid for more than 45 days may be subject to an interest charge of 10% per year.

Your rights as a Patient/Client

You have the right to ask questions about any procedure during therapy. You have the right to decide at any time to stop seeing your provider and if you wish, your provider will provide you with names of other qualified professionals you might prefer. You have the right to end therapy at any time without moral, legal, or financial obligation other than those already accrued.

Authorization and Consent for Treatment

I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I also give my consent for my personal health information to be shared with any other clinicians within innerQuest PLLC (doing business as innerQuest Psychiatry & Counseling)) to which I have been referred.

_____ _____

Initial Date

Insurance Authorization and Assignment

I hereby authorize innerQuest, PLLC to release information necessary to process insurance claims and request payments of benefits to be made to innerQuest, PLLC for services rendered to my dependents or me. I understand that I am responsible for paying any required co-payments and deductibles at the time services are rendered. I hereby authorize my provider and innerQuest Psychiatry & Counseling to release any information required by my insurance carrier to process insurance claims in the course of my examination or treatment. I authorize payment directly to the billing office for my provider and hereby assign payment for the medical benefits, if any, otherwise payable to me for services.

_____ _____

Initial Date

Self-Pay

I have no insurance coverage or I waive the use of insurance. Therefore, I understand that I am responsible for payment at the time services are rendered to me or to my dependents.

_____ _____

Initial Date

_____ _____

Signature of Patient/Legal Guardian/Responsible Party Date:

INNERQUEST
PATIENT REGISTRATION FORM

Please complete this form as completely and accurately as possible. Please print.

Patient Name: (First, Middle, Last)_____

Mailing Address: (Street & P.O. Box)_____

City:_____ State:_____ Zip:_____ SSN:_____

Birth date:_____ Age:_____ Phone#:_____ Alternate#:_____

Preferred Contact for appointment reminders (Please circle): Call/Email or Text/Email

Sex at birth: __F __M Gender: __F __M __Decline Email: _____

Sexual Orientation: (circle one) Heterosexual Lesbian/Gay Bisexual Transgendered Decline

Religious Preference:_____

Marital Status: (circle one) Single Married Domestic Partner Divorced Separated Widowed

Referral Source: _____

Employment Status: (circle one) Full-time Part-time Unemployed Retired Student

If employed, please complete the following:
Employer Name:_____Phone#:_____

Address:_____City_____State_____ Zip_____

Person responsible/or payment (if other than patient):_____
Address:_____City_____State_____Zip_____
Phone #:_____

Spouse/Partner Name:_____Birthdate:_____ Employer:_____

Children: Names/Ages: _____ _____

Primary Care Provider: _____ Phone#:_____

Emergency Contact:
Name:_____Relationship:_____Phone#:_____

Primary Insurance Company:_____Address._____
Insured'sName:_____DOB:_____SSN:_____
ID#:_____ Group Name/#:_____

Secondary Insurance Company:_____Address._____
Insured'sName:_____DOB:_____SSN:_____
ID#:_____ Group Name/#:_____

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FINANCIAL POLICY

- innerQuest will file the charges for each patient's services. InnerQuest will file primary and secondary claims for you. innerQuest does not file tertiary (third) insurances. We will file your secondary insurance once we have received a response from your primary insurance. We will give the secondary 45 days to respond to the claim, and if no response is received, the balance on the account will be turned over to you. It will become your responsibility to contact the secondary for payment. The secondary insurance will be filed only once, as a courtesy to you.

- Patients documented to have no health insurance coverage may be eligible for a reduction in some of their charges with **FULL PAYMENT AT TIME OF SERVICE.**

- Patients with an appointment to see their physician, who also have a delinquent balance of 60 or more days old, will be required to pay their existing balance in full before seeing the physician.

- Balances greater than 60 days are consider delinquent. If the balance is not paid at 120 days and the patient do not respond to innerQuest's attempts to collect an overdue balance, further action may be taken to recover this delinquent account, i.e. a collection agency, and possible dismissal from practice.

_____ _____

Patient Signature Date

CANCELLATION AND NO SHOW POLICY

innerQuest is committed to providing you with exceptional psychiatric and counseling services in a timely manner. Appointments are reserved for you so your provider can set aside time to address your individualized needs. Consistent with our high standards for care, we have established the following polices:

- It is imperative that you attend all scheduled appointments. Your treatment outcome is greatly enhanced by maintaining regular attendance to your sessions. In addition, if you do not attend an appointment, it prevents another patient from being seen that may be waiting for an appointment. Therefore, in the event that you need to cancel an appointment, **we require at least one business day notice prior to your scheduled appointment** (please call by 10AM on Friday if it is a Monday appointment)

- **You will be charged between $100-$150 if you miss your appointment (no show) or if you provide inadequate notice prior to your scheduled appointment. *Please not that your insurance will not pay for these charges.**

- We understand that unpredicted events do occur that may interfere that may interfere with attending a scheduled appointment, such as illness, work conflict, etc. However, repeated late cancellations and no shows affect our ability to provide quality patient care. You may be requested to pay outstanding late cancellations or no-shows fees prior to rescheduling an appointment.

I understand the innerQuest no show / Cancellation policy and Financial Policy and understand my responsibility to plan appointments accordingly and notify innerQuest appropriately if I have difficulty fulfilling my scheduled appointments.

I have read and understand the Financial Policy of innerQuest and well as the Cancellation and No Show policy.

_____ _____

Patient Signature Date

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Notice of Privacy Practices Acknowledgement

I understand that the patient's health information is private and confidential. I understand that InnerQuest Psychiatry & Counseling works very hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that my protected health information can and will be used by InnerQuest Psychiatry & Counseling to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party providers.
- Conduct normal healthcare operations such as quality assessment and physician certifications.

I have received, read, and understand the *Notice of Privacy Practices* of InnerQuest Psychiatry & Counseling, which contains a more complete description of the uses and disclosures of my protected health information, as well as my privacy and confidentiality rights. I understand that InnerQuest Psychiatry & Counseling has the right to change its *Notice of Privacy Practices* from time to time and that I may contact InnerQuest Psychiatry & Counseling at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

My signature below (or that of my legal representative) indicates that I have been given the chance to review a current copy of the *Notice of Privacy Practices* for InnerQuest Psychiatry & Counseling.

Patient Name: _____

Relationship to Patient: _____

Signature: _____ **Date:** _____

OFFICE USE ONLY

I attempted to obtain the patient's (responsible person's) signature in acknowledgement of InnerQuest Psychiatry & Counseling's *Notice of Privacy Practices* on this *Notice of Privacy Practices Acknowledgement Form,* but was unable to do so as documented below:

Date: Initials: Reason: _____

For more information about HIPAA, you may contact the following:
The U.S. Department of Health and Human Services
(202) 619-0257 or (877) 696-6775

Family and Couple Therapy ONLY No Secrets

Policy

(SKIP THIS SECTION UNLESS YOU ARE SEEKING FAMILY OR COUPLE THERAPY)

This policy is intended to inform you, the participants in family or couple therapy, that when your provider agrees to work with a couple or family, your provider considers that couple or family to be "the treatment unit" or patient. For example, if there is a request for the treatment records, your provider may seek authorization from all members of the treatment unit before releasing confidential information to 3rd parties. Also, if your provider's records are subpoenaed, your provider will assert the psychotherapist/patient or psychiatrist/patient privilege on behalf of the patient (the treatment unit). During the course of your work together, your will likely see a smaller part of the treatment unit (e.g. an individual or sibling[s]) for one or more sessions. These sessions should be seen by you as part of the work that your provider is doing with the family or the couple. If you are involved in any such sessions with your provider, please understand that generally these sessions are confidential in the sense that your provider will not release any information to a third party unless your provider is required to do so by law, or unless your provider has your written authorization. In fact, since these sessions can and should be considered part of the family or couple therapy, your provider would also seek the authorization of the other individuals in the treatment unit before releasing confidential information to a third party.

However if your provider is to effectively serve the entire unit being treated, your provider may need to share information learned in an individual session (or a session with only a portion of the treatment unit present) with the entire treatment unit-that is, the family or couple. Your provider will use their best clinical judgment as to whether, when, and to what extent they will make disclosures to the treatment unit. If appropriate, your provider will also first give the individual or smaller part of the treatment unit being seen the opportunity to make the disclosure themselves.

Thus, if you feel it necessary to talk about matters that you absolutely want to be shared with no one, you might want to consult with an individual therapist who can treat you individually. (Your provider will always be happy to refer you to such a person.)

This "no secrets" policy is intended to allow your provider to continue to treat the patient (the couple or family unit) by preventing, to the extent possible, a conflict of interest in which an individual's interests may not be consistent with the interests of the unit being treated. For instance, information learned in the course of an individual session may be relevant or even essential to the proper treatment of the couple or family, and if your provider were not free to exercise my clinical judgment regarding the need to bring this information to the family or the couple during the process of therapy, they might be placed in a situation where they would need to terminate treatment of the couple or family. This policy is intended to prevent the need for such termination.

We, the members of the_____(couple, family or other treatment unit) being seen, acknowledge by our individual initials and signatures below, that each of us has read this policy, that we understand it, that we have had an opportunity to discuss its contents with our provider, and that we are entering into couple/family therapy in agreement with this policy. Each person must initial:

_____ Initials _____ Initials _____ Initials _____ Initials

Principles of Medical Practice

As a mental health professional, I subscribe to a body of ethical standards primarily for the benefit of my patients. I also recognize my responsibility to other health professionals, to society, and to myself.

The following is the standard of conduct that defines the essentials of honorable behavior for physicians, and to which I subscribe.

1. Provider must be dedicated to providing competent medical services, and do so with compassion, integrity and respect for human dignity.

2. Provider shall deal honestly with patients and colleagues; moreover, they must attempt to expose other provider or professional colleagues who demonstrate any deficit in character or competence, or who engage in fraud or deception. Any form of racism, sexism or sexual harassment of patients or staff, or any sexual activity between medical staff or with a patient or their family members is unethical, will not be tolerated, and should be reported to our practice manager immediately.

3. Provider shall respect the law, but also recognize a responsibility and duty to seek changes in any legal requirements that are contrary to the best interest of their patients.

4. Provider shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

5. Provider shall continue to study in their own and related fields of practice, employing with their patients up-to-date scientific knowledge and psychological theory. In addition they shall make all relevant information available to their patients, colleagues and the public, and obtain consultation from other health professionals whenever indicated.

6. In the provision of appropriate patient care (with the exception of emergencies), a provider shall be free to choose whom to treat, with whom to associate, and the environment in which to provide medical services.

7. A provider shall recognize their responsibility to participate in activities which may contribute to an improved community, and act accordingly.

_____ _____

Please sign, indicating that you have read the principles above Date

SUPPLEMENTAL MEDICAL HISTORY

Name_____ DOB:_____

List Medical Hospitalizations, Surgeries, Psychiatric Hospitalizations or Suicide Attempts:

_____
_____
_____

Medication Allergies: (include the specific reaction and severity)

_____
_____
_____

Family Psychiatric History:

_____
_____
_____

Current Tobacco Use:_____ Do you Exercise regularly?_____
Current Caffeine Use:_____ Do you sleep well? _____

Problems with appetite or eating patterns:_____?

Are you currently experiencing overwhelming sadness, grief or depression?_____?

Are you currently experiencing anxiety, panic attacks or have any phobias?_____?

Are you employed?_____If so where?_____Is your work stressful?_____?

Have you experienced any life changes or stressful events recently?_____?
If so, what? _____

Alcohol Use:
Current:

_____
Past issues:

_____

Drug Use:
Current:

_____
Past issues:

_____

Current Height: _____Current Weight:_____ Usual blood pressure _____

I authorize written and verbal communication between innerQuest and:
1. My primary care doctor:_____
2. My therapist: _____

_____ _____
Signature Date

Review of Systems

First Name:_____ Last Name:_____ Date of Birth:_____

Please circle any illness, symptoms or problems that you have had in the last month:

Constitutional
Blood Pressure
Respiration
Fever/sweats
Fatigue
Loss of appetite / weight change

Eyes
Eye Disease of injury
Eye glasses / contact lenses
Blurred / double vision
Glaucoma

Ears / nose/ mouth / throat
Hearing loss
Hearing noises in your ear
Earaches and drainage
Nosebleeds
Trouble swallowing
Bleeding gums
Sore throat
Snoring
Voice changes
Problems with thyroid

Musculoskeletal
Joint pain / stiffness
Muscle pain / cramps / weakness
Backpain

Skin
Rashes
Lesions Ulcers

Cardiovascular
Chest pain / angina
Palpitations
Shortness of breath
Swelling of feet, ankles or hands
Murmur

Respiratory
Cough
Spitting up blood
Shortness of breath
Wheezing

Gastrointestinal
Problems with bowel movements
Nausea/ vomiting
Rectal bleeding / blood in stool
Abdominal pain / heartburn

Genitourinary
Flank pain
Problems with urination
Blood in urine
Kidney stone

Neurological
Headaches
Numbness / tingling sensation
Tremors
Head injury

Hematologic/ lymphatic
Slow to heal after cuts
Tendency to bleed / bruise
Blood clots
Past blood transfusion

Other Symptoms
Memory loss / confusion
Nervousness/ Anxiety
Depression
Insomnia

Completed by; _____ Relationship: _____ Today's Date:_____

My Medication List

Name: _____

Primary Doctor: _____ Phone: _____

Pharmacy: _____ Phone: _____

Medication Allergies (include the specific reaction and severity):

_____

_____

List all prescriptions, over-the-counter medicines, vitamins, herbs, dietary supplements, oxygen, inhalers and homeopathic remedies.

Medication Name / Date Started	Dose (mg, units,drops)	When Taken (daily, at bedtime, etc)	Reason for Taking (blood pressure, Diabetes, etc)

DIRECTONS TO INNERQUEST, PLLC
932 Hendersonville Road Suite 104
Asheville, NC 28803
828-333-5240

****PLEASE NOTE THAT WHILE WE TECHNICALLY HAVE A HENDERSONVILLE ROAD ADDRESS, WE ARE ACTUALLY OFF OF A SMALL SIDE STREET CALLED "SEMINOLE STREET".**

From North Asheville (through town):

I

Take Biltmore Avenue to Hendersonville Road/Hwy 25 South. (office is 2.0 miles south of Mission-St. Joseph's Hospital). Stay on Hendersonville Road/Hwy 25 South. You will pass under I-40, go through four stoplights (the fourth is at South Forest Shopping Center with Ingles Markets and Yesterday's Tree). After the fourth stoplight. you will pass 3 streets, turn LEFT at the fourth street - Seminole Street. (Seminole Street is just past Forest Center North). Go up the hill, turn RIGHT into the parking lot at the top of the hill. *innerOuest* is in Suite 104 &105 of the grey stucco building with_green trim.

From Hwy 19-23 (around town)

Take Hwy 19-23 to I-240 East to t-40 West (just past the River Ridge Exit). Take·I-40 West to Exit 50A (South Asheville/Hwy 25 S), which will loop around and goes under I-40. Follow the above directions under North Asheville starting with the underlined portion of line three.

From Interstate 40 East or West:

From the East: Take I-40 West to Exit 50A (South Asheville/Hwy 25 S), which will loop around and goes under. I-40. Then follow the directions above under North Asheville starting with the underlined portion of line three.

From the West: Take I-40 East to Exit 50 (South Asheville/Hwy 25 S). At the end of the exit ramp turn RIGHT (this stoplight counts as the first stoplight in above directions. Then follow the directions above under North Asheville starting with the underlined portion of line three, noting that the stoplight at the ramp is the first of the four stoplights.

From South Asheville:

From I-26 you may take the Airport Exit in Arden. Turn RIGHT at the top of the exit ramp onto Airport Road and continue down until you get to the light at Hendersonville Road/ Hwy 25. Turn LEFT onto Hendersonville Road - heading North toward Asheville. You will pass such points as: the Blue Ridge Parkway entrance, Carolina Day School, and the new Fresh Market. After passing the light at Carolina Day School, you will continue north and pass through two more stoplight (one at Rock Hill Road and the other at a freestanding CVS on your right). From the stoplight at CVS, drive past two more streets. Turn RIGHT at the THIRD Street, Seminole Street. Go up a short hill and turn RIGHT into the parking lot at the top of the hill. *innerQuest* is in Suite 104 and 105 of the brown stucco building with green trim.