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Walk-In Office Procedure

Rivertown Psychiatry is the only mental health office in the area who offers same day, walk-in appointments for NEW patients.

Please be advised that this service is available for **NEW PATIENTS ONLY**.

All follow-up appointments must be scheduled.

Once this new patient packet is complete:

1. Your information will be entered into our system.
2. We will contact your insurance company to obtain information regarding your benefits.
3. Any deductibles, co-pays, or co-insurance will be collected prior to services.
4. An appointment time will be assigned but please be aware that you may be given an appointment later in the day or possibly another day. Time slots are first come, first serve and only a limited number of new patient slots are available.
5. A urinalysis may be requested prior to your appointment.
6. Please be aware that wait times can exceed one hour after your check-in process is complete.

Even though every effort is made to give you a same-day appointment, we do not imply a guarantee of any kind. We look forward to serving you and your family's needs. We are here when you need us most!

Thanks,

The Team at Rivertown Psychiatry!

Please select service location

☐ Medication Management – Columbus, GA

☐ Counseling Center- Columbus, GA

☐ Psychological Testing- Columbus, GA

☐ Autism (ABA)- Columbus, GA

☐ Counseling – Opelika, AL

☐ Medication Management- Opelika, AL

☐ Medication Management- Lagrange, GA

☐ Counseling- Lagrange, GA

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Patient Registration Form

(All information is confidential)

First Name: _____ Last Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Home Number: _____ Cell Number: _____

Email (For Web Portal): _____

DOB: _____ Sex: M / F / _____

Social Security Number: _____ Sponsor SSN (Tricare Only): _____

Race/Ethnicity: _____ Language: _____

Primary Insurance: _____ Number: _____

Secondary Insurance: _____ Number: _____

Responsible Party Name: _____ DOB: _____

Emergency Contact Name: _____ Cell Number: _____

Pharmacy Preferred: _____

If you/the patient have recently or are currently either suicidal or homicidal (with or without a plan) we are unable to accept this form and recommend that you immediately call 911 or go to the emergency room for evaluation and for necessary treatment.

☐ I certify that the patient is not recently or currently suicidal or homicidal (with or without a plan) and that to the best of my knowledge the patient is not dangerous.

Primary reason for visit: _____

_____

Alternate Reason for Today's Visit: ☐ Suboxone Clinic ☐ Psychiatric Clearance for surgery

☐ I understand and agree that Rivertown Psychiatry does NOT perform any forensic work including but not limited to child custody opinions, court-mandated evaluations, workman's compensation cases or other court / legal matters. I understand that the provider-patient relationship could be immediately terminated if records are requested for the same.

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Person who referred you to us: _____

Primary care physician name: _____

Person completing this form: _____

Other Issues: ☐ Patient is not suicidal, homicidal, or dangerous.

☐ Sadness ☐ Anxiety ☐ Anger ☐ Moodiness

☐ Hallucinations ☐ Impulsiveness ☐ Focus

List any current medical conditions: _____

List current medications: _____

_____

Previous psychiatric diagnoses: _____

List any psychiatric meds ever prescribed: _____

_____

History of substance abuse:

☐ Alcohol ☐ Marijuana ☐ Heroin ☐ Cocaine ☐ Opiates

☐ Ecstasy ☐ Crystal Meth ☐ Suboxone ☐ Pain Meds

Details: _____

_____

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Family Mental Health History: _____

_____

Social History:

☐ Home ☐ School ☐ Employed

School or Employer Name: _____ Grade: _____

Persons living at home with you: _____

_____

Anything else you would like us to know:

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Treatment Consent

I do hereby acknowledge that I am requesting treatment from the providers at Rivertown Psychiatry. If I am bringing a patient to Rivertown Psychiatry, I do hereby give my consent and permission to **Rivertown Psychiatry** to administer treatment to the patient and I attest that I have legal rights to request and administer such treatment. I understand that the physician may order specific medical procedures as part of the treatment. I am aware that I may stop treatment at any time. I am aware that an agent of my insurance company or other third-party payer, may be given information regarding cost, date(s) and/or types of services received. I am aware of my right to have a copy of this statement. I consent that I am responsible for verifying with the insurance company that treatment is covered. In the event the insurance claim is denied, I will be held liable and will pay any outstanding balances to Rivertown Psychiatry.

I consent to this office using any electronic or non-electronic means (including online databases) to obtain prescription history so that the best clinical decisions can be made regarding treatment. I consent to both birth parents having access to records. I consent that Rivertown Psychiatry sends/allows the Primary Care Provider (PCP) and therapist access to medical records. I understand and consent to be treated by providers who may include Nurse Practitioners and Physicians.

I (or any patient in my care) provide informed consent to be treated virtually via tele-psychiatry services (when required) and will initiate the service.

I consent to working with psychological assistants for a portion of the process, If I receive psychological testing. I understand that if I do not come to my appointment to discuss the results of testing, a regular therapy appointment will be made to discuss these results and to receive therapy.

I consent to not using my phone in the providers office for any reason and consent to **bringing my medication bottles** to every appointment or run the risk of not being seen. I will also ensure that I will not leave any children unattended while at the office.

I understand that many medications used may adversely affect pregnant women and unborn children. I consent that if I am currently not using contraceptives, intend to get pregnant or am currently pregnant, I must inform the provider immediately.

I consent that if I (or any patient in my care) relocates, Rivertown Psychiatry will not prescribe medication if unable to find a new provider. It is recommended to schedule your last appointment three days prior to relocating to ensure you have at least 30 days of medication.

I consent to the following: The first visit does not automatically mean/imply that Rivertown Psychiatry providers are assuming the responsibility of psychiatrist. We use the first visit for assessment only. If we determine that we are not able to make rapport or we determine that we are not able to help, we will refer you to other providers in the community who can. If progress is not being made, if treatment recommendations are not being followed or for any reason whatsoever, I consent to being referred to another provider/office at any time.

I consent that if I (or any patient in my care) is not seen in your office once every 3 months, it is assumed that we have fired Rivertown Psychiatry from our care.

I understand that Rivertown Psychiatry does not respond to refill requests that are made by my pharmacy.

I understand that Rivertown Psychiatry does NOT have a physician/telephone operator available on-call 24-hours a day, 7-days a week. I consent and understand that telephone calls may be handled by an answering machine, and I may need to leave a voicemail. It may take up to 48 hours to receive a call back. In case of an emergency, if I (or the patient I am taking care of) experience suicidal thoughts or homicidal thoughts, side effects to medication or any other crisis; I understand that I need to call 911 or go to the nearest Emergency Room. Alternatively, The Bradley Center has a 24-hour intake service if immediate help is needed.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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Urine Test Authorization and Consent

I hereby authorize and give my full consent to allow Rivertown Psychiatry, PC to collect and test a specimen of my urine or send out to a laboratory for screening, to detect the presence of illicit / recreational substances, alcohol, and/ or prescription medication. This authorization and consent form has been explained to me in a language I understand. I have been told that if I have any questions about the urinalysis, I can ask such questions and they will be answered. I understand this is a legal and binding document. I also understand that the results of this test will be confidential.

1. I understand that Rivertown Psychiatry will bill my insurance for a 12-panel cup test. However, certain insurances will only cover 1 panel. I understand if my insurance only covers 1 panel, then I will be required to pay for the other 11 panels at which Rivertown Psychiatry will charge a flat rate of $20. This fee will cover the other 11 uds panels.

2. I understand that if my insurance does not pay for the Urine Drug Screen (UDS), I will be required to pay $20 for the Instant Drug Test Cup (IDT-C).

3. I understand that if I obtain services using telepsychiatry, a urinalysis will need to be obtained in-office as per the office policy.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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Authorization To Be Photographed

I agree to be photographed by a staff member of **Rivertown Psychiatry**. I understand that this photograph will be attached to my active medical record and will be used for identification purposes only. I also understand that **Rivertown Psychiatry** will ensure and promote the strictest standards of confidentiality and that upon my discharge/completion of the treatment program, this photograph will be retired along with any active records and become a permanent addition to my medical records.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

Phone Availability Consent

I understand that Rivertown Psychiatry does NOT have a physician/telephone operator available on call, 24-hours a day, 7-days a week. I consent and understand that telephone calls may be handled by an answering machine, and I may need to leave a voicemail. It may take up to 48 hours to get a call back. In the event of an emergency, if I (or the patient in my care) experience suicidal thoughts, homicidal thoughts, side effects to medication or any other crisis, I understand that I need to call 911 or go to the nearest Emergency Room immediately. If I am the parent or guardian of a patient at Rivertown Psychiatry, I understand that at the first sign of danger, suicidal or homicidal behavior, thoughts, ideas, plan or action, I must call 911. Alternatively, The Bradley Center has a 24-hour a day intake service where I can go if I need immediate help.

I also consent to receiving voicemails, with any information as it relates to my care, from the telephone numbers I have provided to Rivertown Psychiatry.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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Authorization and Consent for Use and Disclosure of Protected Health Information

Name of Patient: _____

Date of Birth: _____

I hereby authorize and give consent for **Rivertown Psychiatry** to request/disclose my protected health information in the following manner:

To Make Telephone Contact With, To Meet With, To Correspond With, To Release To, To Obtain From:

_____

Name of Person/Title: _____

Agency/School: _____

Address: _____

City, State, Zip: _____

Phone/Fax: _____

The following type(s) of information from my records:

All information in records ☐

Other (Specified): _____

I understand this will remain in effect for: _____ (permanently if left blank).

I understand that unless otherwise limited by state or federal regulations and expect to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time. In making this authorization and direction, I certify to **Rivertown Psychiatry,** that I have not been declared incompetent or incapable by any court of law, that I do not have a guardian or other person who has been appointed to manage my affairs, that I understand I may discuss this direction and authorization with counsel; that I release **Rivertown Psychiatry** acting on its behalf for any claim relating to complying with the provisions of this authorization.

_____ / /

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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Controlled Medication Policy Consent

It is the policy of Rivertown Psychiatry to closely monitor the use of controlled medications prescribed to our patients. These medications include, but are not limited to, benzodiazepines, stimulants, sleep medication, pain medication and addiction medication. These medications carry a risk of addiction, often used illegally and, if not managed appropriately, may cause serious injury and/or death.

1. Patients need to complete a scheduled and/or random urine screen to monitor their compliance while on controlled medications.
2. If a patient has a positive urine drug screen for an illicit / recreational substance, we will taper off or immediately discontinue any controlled medications currently being prescribed.
3. If a patient has no evidence of the prescribed medication in the urine screen two consecutive times, we will taper off or immediately discontinue any controlled medications we are prescribing.
4. Additional prescriptions will not be given if the patient runs out of the controlled medication prescribed, i.e., uses the month prescription in less than 30 days.
5. If a patient's prescribed medications are stolen, they must present a police report to verify theft in order to receive a new prescription before it is due.
6. Patients are made aware that he/she can only receive controlled medication prescriptions from our office. If a patient is obtaining similar medications from another medical office as well; no further prescriptions will be given from our office for these medications.
7. Abuse/diversion/medication seeking behaviors will result in termination of care and a referral to another psychiatry office.

I am the patient, or the legal representative and I have read and consent to this policy.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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Financial Policy Consent

Patients of Rivertown Psychiatry and their caregivers are responsible for:

1. Payment before the services are rendered.
2. Verifying that their insurance is active and covers mental health benefits.
3. Verifying that the providers at Rivertown Psychiatry are In-network.
4. Any outstanding payments.
5. Working with a third-party collection agency in case of non-payment.
6. Not scheduling appointments at Rivertown Counseling Center and Rivertown Psychiatry on the same day as insurance may only cover one visit. If so, the patient/caregiver will be responsible for the other.

Cancellation of an Appointment:
In order to be respectful of the medical needs of other patients, please be courteous and call the office promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Calling early on the day is appreciated.

No-Show Policy:
A "no-show" is someone who misses an appointment without calling 24 hours in advance to cancel. There will be a $20.00 charge to the patient if an appointment is missed. If a patient “no-shows”, they may be discharged from the office without notice.

Rivertown Psychiatry is a treatment facility and not a forensic psychiatry office. We do not agree to participate in court proceedings. Diagnoses given are considered provisional and are based on patient history. Patients, their families and caregivers (including DFCS, group-home owners, state agency representatives) agree to compensate Rivertown Psychiatry for any time spent on preparing subpoenas, court mandated appearances, depositions (over the phone or in person) or any other legal issues, at the rate of one thousand dollars an hour.

Medical Records Policy:
I agree to follow Rivertown Psychiatry’s Medical Records Fee Schedule as allowed by law.

I am the patient, or the legal representative and I have read and consent to this policy.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date

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It is the intent of Rivertown Psychiatry and Counseling Center to establish a corporate culture that promotes the rights of the individual, in the overall treatment process at Rivertown Psychiatry. It is the policy of Rivertown Psychiatry to inform the newly admitted consumer of his/her rights, responsibilities, and the grievance/complaint procedure.

PROCEDURES

1. Upon becoming a new patient of Rivertown Psychiatry, the admitting staff will review the "Patient Rights, Responsibilities, and Grievance/Complaint Procedures" and the "Notice of Privacy Practices" with the patient. "Notice of Privacy Practices", "Patient Rights, Responsibilities, and Grievance/Complaint Procedures" must be reviewed annually.
2. The admitting staff will give the patient the opportunity to discuss, question or seek clarification on any item that he/she does not understand.
3. The patient will indicate an understanding of the information by signing this "Acknowledgment of Rights, Responsibilities and Grievance/Complaint Procedure" Form.
4. The signed Acknowledgment form is scanned in the administrative section of the Medical Record.
5. Please visit our website to obtain a copy of the "Patient Rights and Responsibilities" at Rivertown Psychiatry.

PATIENT'S RIGHTS

1. Access to Care: Patients shall be free from discrimination based on age, race, ethnicity, culture, language, physical or mental disability socioeconomic status, sex, sexual orientation and gender identity or expression. Patients have the right to refuse services.
2. Respect and Dignity: Patients will be treated with dignity and respect.
3. Privacy and Confidentiality: The patient has the right, within the law, to personal privacy and information privacy. Rivertown Psychiatry will report child abuse to Child Protective Services, and we will report to the proper authorities in the event that we find evidence of elderly abuse. Although HIPAA generally overrides state laws, HIPAA rules do not apply where the "provision of state law…provides for the reporting of disease or injury, child abuse, elderly abuse, or death, or for the conduct of public health surveillance, investigation or intervention" or where state laws are more stringent than HIPAA rules.
4. Personal Safety and Security: The patient has the right to expect a safe and healthy environment while at Rivertown Psychiatry.
5. Identity: The patient has the right to know the identity and professional status of individuals providing service.
6. Information: The patient has the right to obtain from the provider responsible for his/her care, complete and current information concerning his diagnosis (to the degree known), treatment, pain management, and any known prognosis. This information should be communicated in terms you can reasonably be expected to understand.

When it is not medically advisable to give such information to you, the information shall be made available to a legally authorized individual. You have the right to receive this information in sufficient time to assist you in making decisions whenever possible. The patient has the right to formally access his medical records.

7. Communication: Patients have a right to understand all communication between them and their providers. Regardless of the source of payment for his/her care, the patient has the right to request and receive an itemized and detailed explanation of his/her total finalized bill for services rendered. The patient shall be informed of eligibility for reimbursement by any third-party coverage of services.
8. Consent: The patient has the right to reasonably participate in decisions involving his/her health care. To the degree possible, this shall be based on a clear, concise explanation of his/her condition.
9. Consultation: The patient has the right to consult with another physician.
10. Transfer and Continuity of Care: A patient may not be transferred to another facility unless he/she has received a complete explanation of the need for the transfer and the alternatives to such a transfer. The patient has the right to be informed by the responsible provider or his/her delegate of any continuing healthcare requirements following discharge from another facility. You may be referred to additional services that your provider recommends, but that are not provided here.
11. Rivertown Rules and Regulations: The patient shall be informed of Rivertown Psychiatry rules and regulations applicable to his/her conduct as a patient. Patients must bring all prescription medicine that they are taking to each visit. They must be respectful to providers, administrative staff, and to other patients. The patient must be compliant to schedule appointments and follow the instructions on prescribed medicine.
12. Complaint Process: The patient has the right to file a complaint regarding services and is entitled to information regarding the initiation, review and resolution of such complaints. We will try to contact you within 24 hours after your complaint, and it is Rivertown Psychiatry's intent to have a resolution to your complaint within 48 hours. You have the right to receive information about the resolution of your complaint or alleged right infringement. You have the right to freedom from abuse, financial or other exploitation, humiliation and neglect. You have the right to make a complaint without retaliation. You have the right to refuse to participate in any research conducted by the practice to be notified if such research is offered. You have the right to access legal entities for appropriate representation, to utilize self-help and/or advocacy groups for support and assistance.

Complaint and Appeal Procedures:

1. During check-out there is a patient survey form that is readily available for complaints.
2. Patients can file a complaint on Rivertown Psychiatry website.

Access to After Hour Service:

It is the patient's right to have after hour services. If an emergency occurs after work hours, you may contact the GA Crisis Hotline at 800-715-4225 or call 911 and go to the nearest hospital.

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Patient Responsibilities:

1. Demographics and Contact Information: It is the responsibility of the patient to keep his/her demographics updated with Rivertown Psychiatry; address, phone/cell number, and e-mail address at all times.
2. Insurance: Keeping your insurance active. If you have a primary and secondary insurance, it is your responsibility to keep your COB (Coordination of Benefits- informing both insurance of the other) updated.
3. Co-Pay and Charges: All co-pays, co-insurances, and deductibles must be paid at the time of service.
4. Scheduled Appointment: It is the patient's responsibility to be at all scheduled appointments. You must call within 24 hours of the appointment to cancel or reschedule, or you will be charged a no-show fee.
5. Compliance: Taking medication if prescribed by the physician and reporting its effect on you if any. Patient must be honest in matters concerning his/her treatment. Patients must meet whatever financial responsibilities that may incur as it relates to treatment. Patients must be respectful of the rights and dignity of other patients, providers, and staff members.

Discharge:

Patient will be discharged from the practice if the following occurs:

1. You bring a gun or weapon into the office. (You will not be reinstated)
2. If you bring illegal substances, alcohol, or other substances, (OTC meds, Herbal remedies,) into the office. (You will not be reinstated.)
3. If you harm or threaten any other patient, provider, or staff member. (You will not be reinstated)
4. If you demonstrate that your rapport with the office is reduced to a point where it is in your best interest to be transferred to another office. (You will not be reinstated)
5. If, in the opinion of your provider, you would benefit more from services like wraparound care provided by another office that we do not provide. (You will not be reinstated)
6. If you are not compliant with taking your medication. (You may be reinstated after 3 months with education on the importance of following instructions on taking your meds.)
7. If there is no appointment made for a 3-month period, the patient is considered to have fired us from their care and will no longer be a patient of the practice. (You may be reinstated with education on the importance of making and attending appointments for medication compliance.)
8. If you no-show 3 appointments (without notifying the office within 24 hours) you will be sent a 'Discharge Warning Letter' which states that you will be given 1 week to schedule and keep an appointment. If you do not, you will be discharged. (You may be reinstated after 3 months with education on the importance of keeping scheduled appointments.)

I am the patient, or the legal representative and I have read and consent to this policy.

_____ / / _____

Name & Signature of Patient / Authorized Caregiver (If patient is under 18 years old) Date