**South Lincoln Psychiatry**
**2001 Pine Lake Road, Suite 300**
**Lincoln, NE 68512**
**Phone: (402) 447-7221**
**Fax: (402) 447-7222**

**Kelli D. Bremer, M.D., P.C.**
**Buda Psychiatry, PC**

## Patient Information

**Name**_____ **DOB**_____

**Marital Status:** ⬜ **S** ⬜ **M** ⬜ **W** ⬜ **D** **Gender:** ⬜ **Woman** ⬜ **Man** ⬜ **Person** **Sex:** ⬜ **F** ⬜ **M** ⬜ **UNK**

**Social Security #**_____**Age:** _____**Email**_____

**Address**_____

**City**_____ **State**_____ **Zip**_____

**Home Phone** _____ **Cell Phone**_____ **Work Phone**_____
**Please check if we may we leave a message for you at:** ⬜ **Work** ⬜ **Cell** ⬜ **Home**

**Employer** _____ **Employer's Address**_____

**Emergency Contact** _____ **Phone Number** _____

## Responsible Party and/or Spouse Information

**Name**_____ **Relationship to Patient**_____

**Social Security #**_____ **DOB**_____ **Address**_____

**Employer** _____**Employer's Address** _____

## Insurance Information

**Primary Insurance**_____ **Name of Subscriber** _____

**Subscriber's DOB**_____ **ID #**_____ **Group #**_____

**Subscriber's Address**_____ **Subscriber's Employer**_____

**I authorize Kelli D. Bremer, M.D., P.C. or Buda Psychiatry, PC to release any information acquired in the course of examination to my insurance carrier. This authorization shall remain valid until my written notice is given revoking the authorization. I also authorize direct insurance payments to Kelli Bremer, MD, PC or Buda Psychiatry, PC. I understand that I am financially responsible for all charges whether or not they are covered by insurance. This signature will also authorize consent to treatment for the above named patient.**

**Signature** _____ **Date**_____

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## Consent for Treatment

I, _____, hereby give my consent to _____to provide mental health services to me; or

I,_____, **(Parent/Guardian)** to the above named patient, hereby give my consent for treatment.

_____I allow Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, PC to file for insurance benefits to pay for the care I receive.

_____I understand that:

- Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, P.C. may send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

_____I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my provider.

_____While I anticipate benefits through treatment, I am aware of unforeseen factors that may hinder my counseling and or mental health treatment; I realize that particular results cannot be guaranteed.

_____Counseling and/or mental health treatment may escalate my emotional, mental, or physical conditions; I may experience new stressors during treatment and while attempting to make life changes.

_____The clinician is not providing any emergency services. After hours, holidays or weekends I am to contact 911 or go to the nearest emergency room in the event of a mental health emergency.

_____Regular attendance will assist in maximum benefits. I have been advised that I am free to discontinue treatment at any time. If I decide to discontinue treatment I will notify the clinician at least two weeks in advance so that effective planning or continued care can be implemented.

_____Conversations with the clinician will remain confidential; with the exception of reporting actual or suspected child or elder abuse/neglect to appropriate authorities, and to protect anyone I may threaten with violence, harmful or dangerous actions (including self-endangerment). The clinician is required by law, and has the legal responsibility to report unlawful actions if they cannot be resolved.

I know of no reason why I should not or cannot undertake this counseling and/or mental health treatment and agree to participate fully and voluntarily.

_____ _____
Print Name Date

_____ _____
Patient's Signature Date

_____ _____
Parent or Guardian Signature Date

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# PATIENT'S RIGHTS AND RESPONSIBILITIES

**As a patient you have the right to:**

- Include or exclude family members/significant others in all aspects of your care.
- Be treated with compassion, dignity, and respect.
- Be informed of your treatment including benefits, risks, and reasonable alternatives as well as the risks treatment is refused.
- Participate in the decisions of your treatment plan.
- Understand the treatment modalities being used in your treatment, as well as their benefits and consequences.
- Waive the privilege of confidentiality by signing a release of information.
- Refuse treatment.
- A clear understanding of fees associated with care.
- Be free from verbal, physical, psychological, and sexual abuse.
- Confidentiality to the extent to which the law allows:
  - Exceptions include: suspected child/elder abuse/neglect, potential harm to oneself or others, court ordered treatment and instances when the court subpoenas records.
- Receive an explanation and understand the benefits and/or side effects associated with the use of medications being prescribed.

**As a patient you have the responsibility to:**

- ___ Provide accurate and complete information about your present complaints, past illnesses, prior hospitalizations, types of medication(s) currently using or have used in the past, and other health related issues to your provider.
- ___ Accept responsibility of your decision if refusing treatment.
- ___ Treat others with dignity and respect, including staff, other patients, and providers.
- ___ Respect the property of other persons and South Lincoln Psychiatry
- ___ Assume responsibility for financial obligations.
- ___ Understand and participate in your treatment plan.
- ___ Attend all scheduled appointments and to give 24 hour notice to cancel or reschedule. Understand confirmation calls/notifications are done as a courtesy. Failure to call may result in your discharge from care at South Lincoln Psychiatry and/or being assessed a no show fee no less than **$50.00** per appointment.
- ___ Ask questions about your care.
- ___ Follow your treatment plan.
- ___ **DO NOT** bring alcohol, drugs, weapons, or sharp objects to your appointments.

**Print Patient Name: _____ Date of birth: _____**

**Signature of Patient or Legal Representative:_____Date: _____**
**(If signed by other than patient, state relationship & authority to do so)**

**Witness_____ Date:_____**

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# Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

_____ _____
Patient Name Date

**I understand** that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

**I understand** that Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.
Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, PC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

**I understand** that I have the right to read the *'Notice'* before signing this agreement. If I ask, Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, PC will provide me with the most current *Notice of Privacy Practices*.

**My signature** below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices*. My signature means that I agree to allow South Lincoln Psychiatry, LLC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Kelli D. Bremer, M.D., P.C. OR Buda Psychiatry, PC has taken action relying on this consent.

_____ _____
**SIGNATURE** (Patient or Legal Custodian/Authorized Representative) Date

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Buda Psychiatry, PC

# OFFICE POLICIES

Thank you for selecting South Lincoln Psychiatry, LLC (SLP) which includes the entities of Kelli D. Bremer, M.D., P.C. and Buda Psychiatry, PC. We welcome you to our office.

In order to provide quality care we have provided you with these policies and information.

**By initialing the following you understand and accept these terms:**

**_____CLINICIANS:**
All clinicians at South Lincoln Psychiatry are independent providers and not employees of SLP.

**_____PATIENT REMINDER CALLS:**
This office will make all attempts to call and remind patients of their appointments, with this there may be times we are unable to complete this task. We take this time to remind patients that tracking appointments is ultimately your responsibility.

**_____MEDICATIONS:**
We must follow the rules and regulations of the DEA in prescribing medications. We aim to practice responsible medicine and "do no harm", therefore, at times it may be necessary to take action or precautions against potential abuse or dependency of controlled substances.

**_____MEDICATION REFILLS:**
The most efficient way to request a refill of medication is to call your pharmacy. The exception to this is for ADHD/stimulant medication. Contact the office for refills of ADHD/stimulants Monday to Friday during regular business hours. We will respond to your refill request within 3 business days. No refills are available on evenings, weekends or holidays.

**_____CANCELLATION/NO SHOW APPOINTMENT POLICY:**
Consistency is essential for effective treatment; therefore, we ask that you keep your recommended scheduled appointment. If you are unable to do so, please give at least 24 hours advance notice. Failure to show for your appointment three times may result in termination of services. Patients who fail to show for their appointment without calling the office prior to the start of their appointment, will be considered NO CALL/NO SHOW (NCNS). A bill for $50 will be mailed directly to the patient. The NCNS fee WILL NOT be covered by insurance.

**_____COMMUNICATION/CONTACT WITH THE DOCTORS:**

Our staff will be available to help you during normal business hours (Monday-Thursday from 9am-4pm and Friday from 9am-1pm) at **(402) 447-7221**. If our staff is busy when you call or it is after hours, our voicemail will answer so that you may leave a message. Any messages left after 3pm Monday through Thursday and 1pm on Fridays will be returned the next business day. If your call is not urgent we will make every attempt to return your call within 24 hours with the exception of evenings, weekends, and holidays. If your call is urgent, but NOT an emergency, you may leave a voicemail message. This service however, is not guaranteed as we are an outpatient practice that does not have emergency services. Calls DO NOT substitute an office visit.

_____ Please note texting the office will NOT be monitored or utilized by the providers for communication. Please use voicemail only.

**_____IN AN EMERGENCY:**

Our office does not provide emergency services. If you find yourself in an emergency situation please CALL 911 immediately and/or go to the nearest emergency department.

**_____FINANCIAL POLICY:**

It is the responsibility of the patient to know if their insurance is "in network". If your insurance carrier is considered "out of network" or if you are not using insurance, full payment will be due at time of service. Our office will not file insurance claims to "out of network" insurance plans. If you choose to file the claim with your insurance yourself and need documentation or have questions, please contact Kari with our billing office at 605-881-5903.

Regardless of your insurance coverage, **all outstanding balances and copays will be due at time of service**. If appointment is via telehealth, it is your responsibility to call the office prior to appointment and pay co-pay and/or balance on account. If you are unable to make payment in full at time of service, call to make arrangements with billing prior to visit. Payment is expected **within 30 days** of billing once your insurance has paid. If requests for payments fail to settle an overdue balance, your account may be referred to a collection agency.

**_____SELF PAY AGREEMENT:**

You are responsible for all charges related to services provided by providers of SLP. At check-in new patient evaluations will pay $300 and follow up visits will pay $160 prior to visit. Additional charges may be billed based on complexity and/or time per physician billing after office visit completed.

If you have insurance coverage and are choosing not to use it, be aware that there may be other providers who are in network with your insurance company, and that if you were to see those providers, some/all of your bill could be covered by insurance benefits.

Self Pay Fee Schedule:

| | |
|---|---|
| Outpatient initial evaluation | $300-385 |
| Follow up Appointment | $160- $315 |

**_____ADHERING TO THE TREATMENT PLAN**:

You're expected to follow the treatment plan which is developed collaboratively with you. This means being compliant with medications, keeping appointments and following through with referrals to therapists, other healthcare providers, or substance abuse treatment, etc.

_____**CONTINUATION OF SERVICES**:
Grounds for dismissal from the practice include abuse of medications, failure to follow your treatment plan, failure to follow office policies or procedures, no call no show 3 or more appointments, repeatedly rescheduling appointments, failing to pay your bill in a timely manner or being disrespectful to providers or the office staff.

If you have any questions regarding the above information, please call us at 402-447-7221 and we will be glad to discuss with you.

Thank you!

Dr. Bremer & Dr. Buda

I have read and agree to the terms and conditions listed above.

Print Patient Name: _____ Date of Birth:_____

Patient or Legal Representative Signature: _____
(If signed by other than patient, state relationship & authority to sign for patient)

Date: _____