Chambers & Blohm Psychological Services
309 N Mandan St.
Bismarck, ND 58501

Ph: 701-323-0924
Fax: 701-323-0935
www.chambersandblohm.com

PATIENT REGISTRATION

Patient Name (First, MI, Last) _____

Date of Birth ____/____/_____ ☐ Male ☐ Female ☐ Other

Address

_____
Street Address

_____
City State Zip Code

Phone Number _____ belongs to ☐ Patient ☐ Parent/Guardian

Email Address_____ belongs to ☐ Patient ☐ Parent/Guardian

Emergency Contact Name _____ Relation_____

Phone Number _____

Guarantor/Responsible Party _____
(Write "Self" if you are the patient.)

Primary Care Provider Name _____ Location _____

IF THE PATIENT IS A **MINOR**

Father's Name_____ Custodial rights? ☐ Y ☐ N

Father's Phone Number _____

Mother's Name_____ Custodial rights? ☐ Y ☐ N

Mother's Phone Number _____

(Other Guardian) Name_____ Phone Number _____

Note: Proof of guardianship or other legal authority to act will be requested and maintained on file.

INSURANCE

☐ Check here for self-pay (not using insurance).

Carrier: ☐ BCBS ☐ Sanford ☐ ND-Medicaid ☐ Medicare ☐ Other

Policyholder _____ Date of birth: _____
(Name on card)

Policy (or Medicaid/Medicare) Number _____

If Medicare, please provide the patient's SSN: _____ - ___ - _____

Please note: You, the patient, are responsible for knowing and understanding your insurance coverage/benefits. It is your responsibility to call the insurance company to verify benefits before services are rendered.

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CLINIC POLICIES

CONFIDENTIALITY

You will separately be provided a copy of our Notice of Privacy Practices which outlines how your information may be used and disclosed, as well as how you can access this information.

By your signature below you acknowledge your receipt and understanding of the Notice of Privacy Practices. Generally, the law protects the privacy of information you share with your provider, and we can only release information about your care to others with your written permission. There are a few exceptions because there are some situations in which we are legally obligated to take action to protect you and/or others from harm and in which we are permitted to disclose your information for administrative purposes and/or for coordination of care. Those exceptions are outlined in the Notice of Privacy Practices.

Special considerations re: Autism:
State law (NDCC 23-01-41) requires any mental health care provider who diagnoses a patient with an autism spectrum disorder (ASD) to report the patient's "case" to the state registry for the purpose of conducting epidemiologic studies, research and analysis, and to provide services for individuals with ASD. If you have questions or concerns about this requirement, you are encouraged to discuss them with your provider. For more information, visit www.hhs.nd.gov.

Considerations for Minors:
If you are a parent or legal guardian and are requesting services for a minor, under the age of 18, you will be asked to provide your written consent for treatment.

It is important that the minor develop a trusting relationship with the provider; by providing consent to services, you agree communications between a provider and a minor are confidential.

However, in the exercise of professional judgment, the provider may disclose details of the minor's treatment with a parent and/or legal guardian. Parents and/or legal guardians agree to actively participate in the minor child's treatment, including collaboration with the provider, following provider recommendations, and attending appointments as may be necessary.

TECHNOLOGY & COMMUNICATION

For **scheduling** needs, patients should call the front desk at 701-323-0924. Our office hours are Monday – Thursday 8 am to 5 pm.

For **billing** needs, patients should call the billing manager at 701-877-3051.

To **communicate with their provider**, patients can:

1. Leave a phone message with front desk staff who will relay the message to the provider.
2. Submit their comment or question through the Athena patient portal. [For more information on the Athena portal, please ask a staff person.]

We cannot ensure the confidentiality of **email** communication. Your provider may be willing to respond to emails regarding scheduling or cancellations. However, we request that you do not

use email communication to discuss therapeutic content and/or request assistance for emergencies.
Your providers may use **artificial intelligence (AI)** tools to assist in the development of documentation. If they do, they will only use products that are secure and HIPAA-compliant. There are inherent risks and benefits associated with the use of AI. AI can promote efficiency, creating greater provider availability and, in some instances, reducing cost. AI can, however, include errors, including transcription errors, not unlike what can occur in practice without the use of AI. To address this, we have implemented certain safeguards, including final provider review and verifying compliance with HIPAA and other privacy and security regulations.

APPOINTMENT LENGTH

The standard psychotherapy appointment is 45-50 minutes. Your provider will exercise professional judgment to determine if or when a longer session is medically necessary.

MISSED APPOINTMENTS

There is a $50 fee for no-show or late-cancel (<24-hour notice) appointments. This fee is assessed to reflect the lost opportunity resulting to the practice from untimely cancellation. Please note, this cost is not covered by insurance.

Clients who arrive 15 or more minutes late to a 60-minute appointment will lose that appointment. Clients who arrive 10 or more minutes late to a 20- or 30-minute appointment will lose that appointment.

TERMINATION

You have the right to withdraw your consent to services at any time. Providers may also terminate services, including but not limited to, when:

- It becomes reasonably clear that the patient no longer needs or is benefitting from treatment.
- A patient no-shows or late cancels two consecutive or three total appointments.
- A provider is threatened or otherwise endangered by the patient or other person with whom the patient has a relationship.
- A patient fails to comply with office and billing policies.
- A patient's outstanding balance has been turned over to collections.

In the event of termination, you will be provided advanced notice and referrals for other potential providers, when possible.

LEGAL INVOLVEMENT

On occasion, our providers may be requested or required to consult with a client and/or counsel, create documents outside of a therapy session and designated record set, and/or provide testimony in a legal proceeding. We reserve the right to deny such requests in the exercise of our professional judgment, including for the potential impact on the therapeutic relationship.

Any party who compels or requests consultation, creation of documents, and/or testimony will be responsible for all provider fees associated with the time involved in creating such

documents, attendance, and/or testimony and all related preparation. All of the time incurred will be charged at $300.00 per hour, including all time spent testifying, preparing for legal proceedings, reviewing files, responding to subpoenas and other communication or legal process, and engaging in other related matters that prevent the provider from performing other professional duties. These services are not covered by insurance and will be charged directly to the requesting party at the time of services rendered. By signing below, you acknowledge this policy and agree to its terms, including the assessment of the above-described fees.

OFFICE & WAITING ROOM CONSIDERATIONS

Chambers & Blohm is not responsible for minor children left in the waiting room unattended.

For patients under the age of fifteen (15), the adult who accompanied them to the appointment is expected to stay on-site for the duration of the child's appointment.

Patients are responsible for retention of personal articles. Chambers & Blohm will not assume responsibility for the loss or any damage of patients' personal articles (e.g., money, jewelry, etc.)

Firearms or other weapons are not permitted on the premises. Anyone bringing a weapon into the building will be asked to leave it securely in his or her car. Anyone exhibiting abusive, threatening, or assaultive behavior will be asked to leave. Patients and/or caregivers will not be under the influence when receiving services. Caregivers are expected to disclose information regarding any convicted sex offenders planning to enter the facility to receive prior approval.

Your signature signifies your agreement with the Clinic Policies.
(Those signing electronically can use PDF e-sign features, draw their signature, or simply type their full name.)

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_____ _____

Signature of Patient or Legal Guardian **Date**

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BILLING POLICIES

Chambers & Blohm is happy to assist with the filing of insurance claims and will answer any questions to the extent we are able. However, you are ultimately responsible for knowing your coverage, including No Fault Benefits or Workers' Compensation coverage, as may be applicable, and providing accurate information regarding your coverage, including any changes.

Chambers & Blohm is a participant in the **Medicare** program and does accept Medicare assignment. We will be happy to submit any balance following payment from Medicare to your supplemental insurance. By signing below, you authorize and assign payment of Medicare benefits be made either by you or on your behalf to Chambers & Blohm for any service furnished by listed provider. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services.

By signing below, you authorize and assign payment of any insurance benefits arising from policies insuring the client or a party liable to the client, directly to Chambers & Blohm. You further acknowledge that you understand that you are financially responsible for any charges not covered by insurance. You authorize Chambers & Blohm to release confidential mental health, behavioral health, chemical dependency, and protected health information to third party payers, insurers, Social Security Administrators, and Medicare for this purpose.

In consideration of the services to be rendered to the patient by the provider, you guarantee the payment of any amount due. You understand that co-pays are due at the time of service. Those with financial difficulties should contact the billing manager to discuss payment plan options.

By signing below, you acknowledge you have read the Billing Policies and assume financial responsibility for the expenses of the named patient.

COLLECTIONS

In addition to possible termination of services for non-payment, please be advised we utilize the services of a collection agency for unpaid balances. If utilization of their services is necessary, you may be responsible for any collection fee assessed to collect the debt owed.

GOOD FAITH ESTIMATE/NO SURPRISES ACT

You have the right to receive a "Good Faith Estimate" explaining how much services will cost. Under the law, health care providers need to provide patients who are uninsured or who elect not to use insurance an estimate of the bill for all items and services. For information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (800) 985-3059.

Your signature signifies your agreement with the Billing Policies.
(Those signing electronically can use PDF e-sign features, draw their signature, or simply type their full name.)

★

_____ _____

Signature of Patient or Legal Guardian **Date**