

Christina Agustin, MD

Board Certified in Adult Psychiatry

1 Lake Bellevue Drive, Suite 101 Bellevue, WA 98005

Phone 425-301-9869

Fax: 866-546-1618

*Welcome to my practice. I look forward to meeting with you. Please read each of the items listed below and fill out all forms, to the best of your ability, using **black ink**. Bring a copy with you to our first session.*

NEW PATIENT ENROLLMENT

Enclosed please find the following items for you to review and complete:

New Patient Registration and Acknowledgment of Receipt of Notice of Privacy Practices & Policies, Receipt of Notice of Office Policies & Procedures

Insurance Information and Help Sheet: "Checking your outpatient mental health insurance benefits"

Billing and patient accounts are administered by *Northwest Clinical Billing*

Phone: 800-831-3322

Fax: 360-491-8007

Email: linda@nwclinical.com

Authorization of assignment of benefits to release information for treatment, billing, or healthcare operations*

**Authorization is not required for treatment. However, it may be required for sending your insurance company additional information requested for claims processing.*

Authorization to exchange patient health information with other providers, if indicated

Notice of Office Policies & Procedures for Christina Agustin, M.D. (for your records)

Notice of Privacy Practices & Policies for Christina Agustin, M.D. (for your records)

Thank you for your kind consideration. I look forward to meeting you in the near future.

Christina Agustin, M.D.

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NEW PATIENT REGISTRATION

GENERAL INFORMATION

Name: _____ DOB: _____ Sex: _____

Mailing Address: _____

City, State, Zip: _____

SSN: _____ Employer: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____

Best message phone? Home Mobile

Work email: _____

May we send a message? Yes No

Home email: _____

May we send a message? Yes No

MEDICAL AND REFERRAL INFORMATION:

Name of Primary Care Provider: _____

Telephone Number: _____ Fax Number: _____

Name of Pharmacy: _____

Pharmacy Telephone: _____ Pharmacy Fax: _____

Who referred you to our practice? _____

Acknowledgment of Receipt of Notice of Privacy Practices and Policies and Acknowledgement of Receipt of Notice of Office Policies and Procedures

I have received a copy of the Notice of Privacy Practices and Policies and a copy of the Notice of Office Policies and Procedures from Christina Agustin, MD. I understand the cancellation policy.

Patient Signature: _____ Date: _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____

HEALTH INSURANCE INFORMATION

In order for any claims to be submitted to your health insurance company, the following information must be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s). Questions? Call NW Clinical Billing 1-800-831-3322, or email linda@nwclinical.com. Also, see form "Checking your Insurance Benefits" for questions to ask when you call your insurance provider.

PRIMARY HEALTH INSURANCE

Primary Insurance Company: _____
Patients Relationship to Subscriber: Self Spouse Child Other _____
Patient ID: _____ Patient Birth Date: _____
Subscriber ID: _____ Subscriber Birth Date: _____
Subscriber Insurance Group #: _____ Subscriber SSN: _____
Subscriber Address: _____

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: _____
Patients Relationship to Subscriber: Self Spouse Child Other _____
Patient ID: _____ Patient Birth Date: _____
Subscriber ID: _____ Subscriber Birth Date: _____
Subscriber Insurance Group #: _____ Subscriber SSN: _____
Subscriber Address: _____

ASSIGNMENT OF BENEFITS

I hereby assign to *Christina Agustin, MD* my right to the insurance benefits that may be payable to me for the services provided, in my name or in my behalf. I further authorize those payments be made directly to *Christina Agustin, MD*. I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services. The doctor may release all or part of my medical record to the insurance company required for processing any claims. The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.

Patient Signature: _____ Date: _____

CHECKING YOUR OUTPATIENT MENTAL HEALTH INSURANCE BENEFITS

Please contact NW Clinical Billing 1-800-831-3322 before your 1st visit. Health insurance plans vary in the kinds of outpatient mental health services they cover. Here are some important questions to understand about your coverage when checking on your benefits and eligibility.

Telephone number to call to check my benefits and eligibility: _____

Does my insurance cover *outpatient mental health* services? Yes No

Is my health insurance coverage *active*? Yes No

If yes, my policy became effective on: _____

Are my mental health benefits based on a calendar year? Yes No

If not, my benefits are based on this range of dates: _____

How many outpatient mental health *visits* are covered for one (1) year? _____

How many *remaining visits* do I have for the current year?

Is Dr. Agustin a "*preferred*" or "*in-network provider*" for my health insurance plan?
(Please be sure to specify the practice address.) Yes No

For Dr. Agustin's services:

Do I pay a *co-pay* for each visit? Yes No

If yes, my co-pay amount for each visit is: _____

Do I have a *co-insurance* cost for each visit (a percentage of the charge that I have to pay myself)? Yes No

If yes, my co-insurance percentage for each visit is: _____

Do I have to obtain an *authorization* for Dr. Agustin's services? Yes No

If yes, who must call? My referring provider Myself Dr. Agustin

The number to contact to obtain an authorization is: _____

Before the 1st appointment, you should understand the above information. Please be sure to bring this form with you to your first appointment. Thank you.

Patient Signature: _____ **Date:** _____

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NOTICE OF OFFICE POLICIES AND PROCEDURES

PURPOSE OF THIS INFORMATION

In order for me to provide the best care possible, I want my patients to have as much pertinent information as is possible. If you have any questions or concerns about the healthcare or business practices of this office, please feel free to discuss them with me.

EMERGENCY CONTACT

If you are experiencing a medical emergency and/or need rapid attention for your own or someone else's safety, please dial 911, or report to the nearest hospital emergency room. Do not delay by waiting for a return call.

OFFICE HOURS

Office hours are from 9:00am to 2:00pm, Monday, Tuesday, Thursday, and Friday. Please call 425-301-9869 to schedule/reschedule appointments and for routine clinical matters. Calls will be returned within the next business day, with the exception of Tuesday, when calls will be returned when I return to the office on Thursday.

AFTER HOURS

For urgent calls, you may call 425-301-9869. On Fridays and weekends, a message on this line will indicate a number to call, as the call rotates among a group of private psychiatrists from 5:00pm Friday until 8:00am Monday.

PRESCRIPTIONS

To refill prescriptions, please call your pharmacy and request it to be faxed to 866-546-1618 with patient name, date of birth, milligram dosage and directions, pharmacy name, and pharmacy fax number. Please allow 48 hours to respond. **Please note:** Over the weekend, there is a covering psychiatrist on call who will only fill a 3-day supply of medication, and will **not** fill narcotics or stimulants. Please try to be aware of how much medication you have and request your refills early and during the week.

LATE CANCELLATIONS AND MISSED APPOINTMENTS

Cancellations must be received 24 hours in advance, by the previous business day (on Friday for a Monday appointment). Failure to keep a scheduled appointment will result in a charge of \$75.00. Exceptions to this include emergencies outside of your control. Please note that insurance health plans do NOT pay for missed appointments; these charges will be entirely your responsibility.

INSURANCE BENEFITS AND PATIENT RESPONSIBILITY FOR FEES

Please contact your insurance company to clarify your benefits. If charges are denied by a health insurance plan they become entirely your responsibility. Payment for charges not covered by your health insurance plan (including co-pays and deductible amounts) is due in full at the time services are provided unless prior arrangements have been made. My billing and patient accounts are administered by Northwest Clinical Billing at 1-800-831-3322. Please contact them directly with any questions about your account.

UNPAID BILLS

It is important that you discuss with me any financial hardship that you may have. Doing so may allow us to arrive at a mutually agreeable payment plan that allows the continuation of your treatment. If this cannot be accomplished, seriously delinquent accounts may be referred to a collection agency and we may have to terminate our relationship as provider and patient. Information necessary to effect collection will be released to the collection agent. A service fee of 1.5% will be charged on balances more than ninety (90) days past due based on date of service.

FEES

Fees as of October 1, 2012, are \$300.00 for the first appointment (90801) in an episode of care. Fees for subsequent individual appointments are \$220.00 for an appointment of 40-45 minutes (90807), \$200 for therapy (90806), \$150.00 for an appointment of 20-30 minutes (90805), and \$125.00 for a 15-20 minute medication check (90862).

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NOTICE OF PRIVACY PRACTICES AND POLICIES

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by *Christina Agustin, M.D.* whether created by me, my personnel or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

WAYS THE PRACTICE MAY USE AND DISCLOSE YOUR INFORMATION

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information (PHI) (information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the following categories.

A. DISCLOSURES WHICH REQUIRE AUTHORIZATION

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or healthcare operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

Confidential information may be released for payment and healthcare operations only to health insurance plans and their agents and business associates of the practice. The definition of health insurance plan does not include life insurance companies, automobile insurance companies, or workers' compensation carriers. These are not covered under HIPAA. Therefore, if you would like information submitted to one of these companies, an authorization will be required, unless I am otherwise required by state or federal law.

B. ROUTINE SITUATIONS

- 1. For Treatment** I may use information about you to provide you with medical treatment or services. Treatment is when I provide, coordinate, or manage your healthcare and other services related to your healthcare. An example of treatment is when I consult with another healthcare provider, such as your primary care physician.
- 2. For Payment** I may use and disclose information about you so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company, or a third party (including a collection agency if necessary). For example, I may give your health insurance plan information about services you received at the practice so your health insurance plan will pay my practice or reimburse you for the services. I may also tell your health insurance plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.
- 3. For Healthcare Operations** I may use and share information about you for administrative functions necessary to run my practice and promote quality care. I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services. I will contractually bind these third parties to protect your information as I would. Also, I may permit your health insurance plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.
- 4. Communicating with You and Others Involved in Your Care** My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

C. SPECIAL SITUATIONS

- 1. As Required By Law:** I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid court subpoena.
- 2. Health Oversight Activities:** I may disclose information to a health oversight agency for activities authorized by law. These oversight activities include, for example: audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- 3. For Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that you have received within my practice and the records thereof, such information may be privileged under state law, and I will not release information without the written authorization of you or your legal representative, or in instance of issuance. This may also be the case in the instance of a court subpoena requiring provision of such information of which you have been properly notified and in response to which you have not opposed the court subpoena within the legally specified format and timeframe, or in the instance of the issuance of a court order compelling me to provide Protected Health Information (PHI). This privilege does not apply when you are being evaluated for a third party or where the evaluation is court-ordered. You will be informed in advance if this is the case.
- 4. To Avert Serious Threat to Health or Safety:** I may disclose your confidential mental health information to any person without authorization if I believe reasonably that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual. These disclosures may be to law enforcement officials to respond to a violent crime or to protect the target of a violent crime. For example, threat of harming another individual may be reported to appropriate authorities.
- 5. Worker's Compensation:** If you file a worker's compensation claim, with certain exceptions, I must make

available, at any stage of the proceedings, all PHI information in our possession that is relevant to that particular injury in the opinion of the Washington Department of Labor and Industries, to your employer, your representative, and the Department of Labor and Industries upon request.

6. **Public Health Risks:** I may disclose information about you for public health activities. These activities generally include, but are not limited to, the following:
 - a. To prevent or control disease, injury, or disability
 - b. To report child abuse or neglect
 - c. To report adult and domestic abuse
 - d. To report reactions to medications or problems with products
 - e. To notify people of recalls of products they may be using
 - f. To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
 - g. To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.
7. **Law Enforcement:** I may release information about you if asked to do so by a law enforcement official:
 - a. In response to a court order, subpoena, warrant, summons, or similar process
 - b. To identify or locate a suspect, fugitive, material witness, or missing person
 - c. If you are suspected to be a victim of a crime, generally with your permission
 - d. About a death we believe may be the result of criminal conduct
 - e. About criminal conduct at the hospital
 - f. In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime

YOUR RIGHTS AS A PATIENT

In addition to provisions by the practice to protect your confidential information, you are entitled to six (6) specific rights as a patient.

1. **You have the right to request restrictions on certain uses and disclosures.** You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, administrative functions, or with individuals involved in your care. To request restrictions, you must make your request in writing to me. In your request, you must tell me: (1) what information you want to limit; (2) whether you want to limit use, disclosure, or both; and (3) to whom you want it to apply. I am not required to agree to your request. If I agree, I will comply with your request unless the information is needed to provide you with emergency treatment.
2. **You have the right to receive confidential communications.** You have the right to request that we communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing to me. Your request must specify how or where you wish to be contacted. I will not ask you the reason for your request. I will seek to accommodate all reasonable requests.
3. **You have the right to inspect and obtain copies.** You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes, information compiled in reasonable anticipation of a legal action or proceeding; and confidential information related to certain laboratory tests under Clinical Laboratory Improvement Amendments (CLIA). To inspect and copy information that may be used to make decisions about you, you must submit your request to me in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. In the following circumstances I may deny your request to inspect and copy information:
 - a. I have determined, in the exercise of professional judgment, that the access requested is reasonably likely to endanger the life or physical safety of you or another person
 - b. The information makes reference to another person (unless the other person is a healthcare provider) and I have determined, in the exercise of professional judgment that the access requested is reasonably likely to cause substantial harm to the other person
 - c. The request for access is made by your representative and I have determined, in the exercise of professional judgment that the provision of access to your personal representative is reasonably likely to cause substantial harm to you or another person. If you are denied access, you may request a review of the denial by another licensed medical practitioner. I will comply with the outcome of the review. If your request only concerns billing information, contact NW Clinical Billing 1-800-831-3322.
4. **You have the right to amend confidential information.** If you feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. You have the right to request an amendment for as long as the information is kept by or for my practice. To request an amendment, your request and a reason that supports your request must be made in writing and submitted to me. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask me to amend information that:
 - a. Was not created by my practice, unless the person or entity that created the information is no longer available to make the amendment. In such instances I would consider the request
 - b. Is not part of the information kept by or for my practice
 - c. Is not part of the information which you would be permitted to inspect and copy
 - d. Is accurate and complete
5. **You have the right to receive an accounting of disclosures of confidential information.** You may ask to receive an accounting of certain disclosures made about you that were not related to the routine uses listed above. To request this list or accounting of disclosures, you must submit your request in writing to me. Your request must state a time period that may not be longer than six (6) years and indicate what format you want the list (for example on paper or in an electronic file). The first list you request will be free. For additional lists, I may charge you the cost of providing the list. I will notify you of the estimated cost involved and you may choose to withdraw or modify your requests because any costs are incurred. Disclosures do not have to be made when those disclosures are:
 - a. To carry out treatment, payment and healthcare operations
 - b. To individuals of confidential information about them
 - c. As a result of assigned authorization
 - d. For the practice's directory or to persons involved in your care
 - e. For national security or intelligence purposes; or
 - f. To correctional institutions or law enforcement officials
6. **You have the right to obtain a paper copy of this Notice upon request.** Even if you have requested an electronic copy, I will provide you with a paper copy of this Notice at your request.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to Protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. I will promptly revise and distribute my Notice whenever there is a change to the uses or disclosures, your rights, and my duties, or other privacy practices stated in this Notice. I will mail updates of my notice to all active patients. Patients who are inactive at the time of mailing may receive an updated copy at their next scheduled appointment. A copy of the current Notice will be available throughout my practice. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

OTHER USES OF INFORMATION

Other uses and disclosures of information not covered by this notice or the laws that apply to my practice will be made only with your written permission. If you provide my practice with specific permission to use or disclose information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, I will no longer use or disclose information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures that have already been made with your permission and that I am required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. You may contact me with questions or comments at (425) 301-9869, or by mail at Christina Agustin, M.D., 1 Lake Bellevue Drive, Suite 101, Bellevue, WA 98005.

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AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

I authorize *Christina Agustin, MD* to release / obtain information from the records of:

Patient Name: _____ Date of Birth: _____

INFORMATION TO BE EXCHANGED WITH:

Organization/Individual: _____

Mailing Address: _____

Telephone: _____ Fax: _____

I authorize my records to be faxed to the number provided above. **Patient Initials:** _____

INFORMATION TO BE EXCHANGED:

- Inpatient psychiatric discharge summary
- Outpatient psychiatric evaluation
- Laboratory/test reports
- Summary of medical or psychiatric history and treatment, including progress notes
- Psychological testing/assessment
- Chemical dependency records
- Psychiatric treatment
- Treatment plan
- All records
- Crisis plan
- Progress notes for dates: _____
- Psychiatric medical notes for dates: _____
- Other (please specify): _____

FOR THE PURPOSES OF:

- Participation in psychiatric evaluation and/or treatment services
- Coordination of care between multiple providers
- Transfer of care to a new provider
- Other (please specify): _____

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to *Christina Agustin, MD*. I understand that once the information has been released according to the terms of this authorization that the information cannot be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authority at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with Dr. Agustin has ended or one year after date of last visit, unless otherwise specified here:

Patient Signature: _____ **Date:** _____

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: _____ Relationship to Patient: _____