MOUNTAIN VIEW PSYCHIATRY, LLC 2021

Kevin N. Batterbee, D.O. • Trudy Wilson, MS, LPC
13550 Northgate Estates Drive, Suite #100, Colorado Springs, Colorado 80921
Phone: (719) 375-1491 • Fax: (719) 445-0082

REGISTRATION FORM

IN ORDER TO FILE CLAIMS WITH YOUR INSURANCE, **PLEASE COMPLETE ENTIRE FORM LEGIBLY**

Name: _____ **Date of Birth**: _____
Sex: **M**___**F**___ **Social Security #**: _____ **Marital Status**: _____
Address: _____**City**_____**ST**_____**Zip Code**_____
Who referred you to Mountain View Psychiatry? _____
Email address: _____
Best phone # to reach you: **Cell Phone #**: _____ **Home Phone #**: _____
Work #: _____ **Employer and Employer's Address**: _____

**Parent or Guardian if Patient is under 18 years of age*
***Parent/ Guardian Name**: _____ **Relationship to Patient**: _____
Address: _____
Street **City** **State** **Zip**
Cell phone #: _____ **Home phone #**: _____ **Work #**: _____

INSURANCE INFORMATION

Primary Insurance : _____ **Name of Primary Insured**: _____
Your Relationship to Primary Insured (circle one): **self / spouse / child**
Primary Insured DOB: _____ **Primary Insured Social Security #**: _____-_____-_____
Insurance ID#: _____ **Group or Policy #**: _____
Claims Address _____
Insurance Phone #: _____ **Effective Date**: _____

Secondary Insurance: _____ **Name of Insured**: _____
Your Relationship to Primary Insured (circle one): **self / spouse / child**
Insured DOB: _____ **Insured SS # or ID #**: _____-_____-_____
Insurance ID#: _____ **Group or Policy #**: _____
Claims Address _____
Insurance Phone #: _____ **Effective Date**: _____

Authorization: Payment is expected at the time of service. The above information is warranted to be true. I agree to be responsible for the charges incurred. If insurance is available, I authorize release of information for the purpose of filing claims, and also authorize payments of benefits directly to Mountain View Psychiatry, LLC.

Cancellation of appointments must be made 24 hours in advance to avoid a $50 failed appointment charge.
This fee is due prior to the next appointment. By signing this document, you understand and agree to the terms.

Print Name: _____Signature: _____ **Date:** _____
Relationship to patient (if not signed by patient): _____

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FINANCIAL POLICY AND PATIENT RESPONSIBILITIES

By initialing, you *understand* your responsibilities and *agree* to this policy.

1. Co-pays are due at the time of your appointment. If you are not able to pay your required co-pay, please reschedule your appointment for another time. Please do not ask us to make an exception to this policy. _____**initial**
2. You are responsible for any payments including deductibles. We reserve the right to suspend scheduling appointments for non-payment. It is your responsibility to update your insurance information for timely filing. **NO FURTHER SERVICES WILL BE PROVIDED UNTIL YOUR ACCOUNT IS UP-TO-DATE.** _____**initial**
3. Initial visits with Dr. Batterbee are 45-60-minute appointments and follow-up visits are 20-30-minute appointments. If you extend beyond this time, your insurance will be billed for an extended appointment and you may be responsible for extra deductibles or coinsurance. Visits with Trudy Wilson, MS, LPC are 60-75 initially and 45-60 minutes each follow-up visit. _____**initial**
4. **Please be on time for your appointment. If you will be 15 or more minutes late, your appointment will be rescheduled and *you will be charged a no-show fee of $50.00 or $75.00 depending on whom you were scheduled to see.*** _____**initial**
5. **We strictly enforce a no-show policy**. A missed appointment fee will be charged for missed follow-up appointments and for missed initial appointments. You will be charged if you do not attend your scheduled appointment or you cancel with less than 24 hours. This fee is your responsibility and will not be charged to your insurance. It will be due prior to scheduling your next appointment. Failure to pay this fee may result in suspension of appointment scheduling privileges. We will keep your credit card on file to charge this fee.
   Fees are as follows:
   Trudy G. Wilson, LPC - No Show New Patient: **$100.00** No Show Existing Patient: **$50.00** _____**initial**
   Kevin N. Batterbee, D.O.- No Show New Patient: **$150.00** No Show Existing Patient: **$75.00** _____**initial**
6. **Three (3) missed and or last-minute cancelled appointments will result in discharge from our practice.**
   If you have questions, please speak with your provider. _____**initial**
7. Due to being a mental health facility, possession of firearms or weapons of any kind are strictly prohibited. _____**initial**
8. Referrals and prior authorizations for services received are the responsibility of the patient (or patient's guardian if patient is a minor). Services that are not covered because of failure to obtain referral or prior authorization are the patient's responsibility**.** _____**initial**
9. Fee-for-service, cash, or uninsured patients will be required to pay the entire fee prior to seeing the provider. _____**initial**
10. If patient is a minor, patient must be present at every appointment in order to bill your insurance. If you wish to schedule an appointment without the patient present, the out-of-pocket fee will be $125 per half an hour. _____**initial**
11. **We require a notice of 7 business days for any refill requests**. It is not our responsibility to keep track of how many days you have left of your medication. _____**initial**
12. If you require a provider to complete disability paperwork, you will be required to schedule a separate appointment **or** will be charged an out-of-pocket rate of **$250** which is due *prior* to the receipt of the paperwork. _____**initial**

FINANCIAL POLICY AND PATIENT RESPONSIBILITIES 2021

_____(Initial) I WISH TO RECEIVE A COPY OF THIS FINANCIAL POLICY

or

_____(Initial) A COPY OF THE FINANCIAL POLICY WAS OFFERED AND I DECLINE AT THIS TIME

I, the undersigned, have **received/declined** (**please circle one**) a copy of the Financial Policy of Mountain View Psychiatry, LLC and understand that I am responsible for following the policy guidelines. I also understand that failure of payment as outlined in the policy may suspend my ability to schedule appointments with my provider until payment arrangements have been made.

Patient/Responsible Party Signature: _____**Date**: _____

PLEASE KEEP THIS PORTION FOR YOUR OWN RECORDS

MOUNTAIN VIEW PSYCHIATRY, LLC
Kevin N. Batterbee, D.O. • Trudy Wilson, MS, LPC
13550 NORTHGATE ESTATES DRIVE, SUITE 100
COLORADO SPRINGS, CO 80921

NOTICE OF PRIVACY PRACTICES

The privacy of your health information is important to our practice. Mountain View Psychiatry, LLC will maintain the privacy of your health information and we will not disclose your information to others unless instructed by you, the patient, to do so, or unless the law authorizes or requires our practice to do so.

A new federal law commonly known as HIPAA requires that we take additional steps to keep you informed about how we may use information that is gathered in order to provide health care services to you. As a part of this process, we are required to provide you with the attached Notice of Privacy Practices and to request that you sign the attached written acknowledgement that you received a copy of the Notice. The Notice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. This Notice also describes your rights regarding health information we maintain about you and a brief description of how you may exercise these rights.

If you have any questions about this Notice, please contact Dr. Kevin Batterbee, D.O. at (719) 375-1491

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI"). We must follow the privacy practices that are described in this Notice, which may be amended from time to time.

For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

I. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI)

A. Permissible Uses and Disclosures without Your Written Authorization

We may use and disclose PHI without your written authorization, excluding Psychotherapy Notes as described in Section 2, for certain purposes as described below. The examples provided in each category are not meant to be exhaustive, but instead are meant to describe the types of uses and disclosures that are permissible under federal and state law.

1. Treatment: We may use and disclose PHI in order to provide treatment to you. For example, we may use PHI to diagnose and provide counseling service to you. In addition, we may disclose PHI to other health care providers involved in your treatment to the extent they need to know the information.

2. Payment: We may use or disclose PHI so that services you receive are appropriately billed to, and payment is collected from, your health plan. By way of example, we may disclose PHI to permit your health plan to take certain actions before it approves or pays for treatment services.

3. Health care Operations: We may use and disclose PHI in connection with our health care operations, including quality improvement activities, training programs, accreditation, certification, licensing or credentialing activities.

4. Required or Permitted by Law: We may use or disclose PHI when I am required or permitted to do so by law. For example, I may disclose PHI to appropriate authorities if I reasonably believe that you or someone else is a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. In addition, I may disclose PHI to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. Other disclosures permitted or required by law include the following: disclosures for public health activities; health oversight activities including disclosures to state or federal agencies authorized to access PHI; disclosures to judicial and law enforcement officials in response to a court order or other lawful process; disclosures for research when approved by an institutional review board; disclosures to military or national security agencies, coroners, medical examiners, and correctional institutions; in the event of a medical emergency, emergency personnel or services providers may be given necessary information; if you bring a complaint against Family Services; in the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure; in the event you reveal the contemplation or commission of a crime or harmful act; for auditing purposes or state licensing review; or as otherwise authorized by law

B. Uses and Disclosures Requiring Your Written Authorization

We are bound by professional ethics to protect client rights to confidential communications in regards to their involvement in counseling. For this reason, if information about your participation in therapy is to be released to anyone, we will require a signed "Release of Information" from you for any of the following:

1. Psychotherapy Notes: Notes recorded by your therapist documenting the contents of a counseling session with you ("Psychotherapy Notes") will be used only by your therapist and will not otherwise be used or disclosed without your written authorization.

2. Marketing and Fundraising Communications: We will not use your health information for marketing or fundraising communications without your written authorization.

3. Other Uses and Disclosures: Uses and disclosures other than those described in Section I.A. above will only be made with your written authorization. For example, you will need to sign an authorization form before I can send PHI to a school or to your attorney. You may revoke any such authorization at any time.

II. YOUR INDIVIDUAL RIGHTS

A. Right to Inspect and Copy. You may request access to your medical record and billing records maintained by us in order to inspect and request copies of the records. All requests for access must be made in writing. Under limited circumstances, we may deny access to your records if we believe the information may be harmful to you or someone else. You have the right to appeal any denials. We may charge a fee for the costs of copying and sending you any records requested. If you are a parent or legal guardian of a minor 13 years or older, please note that certain portions of the minor's record that includes information pertaining to mental health, drug treatment or family planning will not be accessible to you.

B. Right to Alternative Communications. You may request, and we will accommodate, any reasonable written request for you to receive PHI by alternative means of communication or at alternative locations.

C. Right to Request Restrictions. You have the right to request a restriction on PHI we use or disclose for treatment, payment or health care operations. You must request any such restriction in writing addressed to the Privacy Officer as indicated below. We are not required to agree to any such restriction you may request.

D. Right to Accounting of Disclosures. Upon written request, you may obtain an accounting of certain disclosures of PHI we make after April 14, 2003. This right applies to disclosures for purposes other than treatment, payment or health care operations, excludes disclosures made to you or disclosures otherwise authorized by you, and is subject to other restrictions and limitations.

E. Right to Request Amendment: You have the right to request that I amend your health information. Your request must be in writing, and it must explain why the information should be amended. I may deny your request under certain circumstances.

F. Right to Obtain Notice. You have the right to obtain a paper copy of this Notice by submitting a request to our Privacy Officer at any time.

G. Questions and Complaints. If you desire further information about your privacy rights, or are concerned that we have violated your privacy rights, you may contact the **Privacy Officer** Keith Myers at 206-826-3050 X 126. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. We will not retaliate against you if you file a complaint with the Director, our Privacy Officer, or myself.

III. EFFECTIVE DATE AND CHANGES TO THIS NOTICE

A. Effective Date. This Notice is effective on April 14, 2003.

B. Changes to this Notice. We may change the terms of this Notice at any time. If I change this Notice, I may make the new notice terms effective for all PHI that I maintain, including any information created or received prior to issuing the new notice. If I change this Notice, I will post the revised notice in the waiting area of my office. You may also obtain any revised notice by contacting the Privacy Officer.

THIS PORTION MUST BE SIGNED AND RETURNED

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I _____ acknowledge that I have received a copy of the Notice of Privacy Practices for Kevin Batterbee, D.O.

_____ _____

Signature of client (or personal representative) **Date**

If this acknowledgement is signed by a personal representative on behalf of the client, please complete the following:

Personal Representative's Name: _____

Relationship to Client: _____

FOR OFFICE USE ONLY

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practiced, but acknowledgment could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

This form will be retained in your medical record.