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stepping stones psychiatric care

DEMOGRAPHIC INFORMATION

First Name: _____ Last Name: _____ DOB: _____

SEX: Male/Female/TransGender Pronoun: _____ RACE: Hispanic/Non-Hispanic

MARTIAL STATUS : Single/Married/Divorced/Widowed/Separated VETERAN: Yes/No

Street Address: _____ City: _____ State: ____ Zip: _____

Cell Phone: _____ Ok to Text Reminder Y/N Work Phone _____

Email Address: _____ Employer Name: _____

EMERGENCY CONTACT

Name: _____ Phone : _____ Relationship: Parent/Guardian/Spouse/Child

Name: _____ Phone : _____ Relationship: Parent/Guardian/Spouse/Child

PARENT / LEGAL GUARDIAN (If Applicable)

Last Name: _____ First Name: _____ DOB: _____
Phone Number: _____ Living with Child ? Yes _____ No _____
Street Address: _____ City: _____ State: ___ Zip Code: _____
If Applicable, Circle One: Child is Adopted Under Guardian Care Under Foster Care

PRIMARY INSURANCE

Insurance Name: _____ Insurance Phone: _____
Policy Number: _____ Group Number: _____
Policyholder Name: _____ Policyholder DOB: _____
Relationship to Patient: Self/Parent/Guardian/Spouse Employer: _____

SECONDARY INSURANCE

Insurance Name: _____ Insurance Phone: _____
Policy Number: _____ Group Number: _____
Policyholder Name: _____ Policyholder DOB: _____
Relationship to Patient: Self/Parent/Guardian/Spouse Employer: _____

REFERRAL SOURCE

Who Referred You To Our Services : _____

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MS LEGACY - STEPPING STONES PSYCHIATRIC CARE : GENERAL CONSENT

Welcome to MS Legacy - Stepping Stones Psychiatric Care (SSPC).

I (Print Name) _____ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		**Relative, Facility, Agency, Healthcare Provider**	
Name:	MS Legacy – SSPC	**Name:**	
Address:	Emerson Lane #1303	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:
__ Admission & Intake Data __ Clinical Needs __ Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__ Discharge Plans __ Evaluation Summary __ Lab Reports __ Medication Management __ Progress Notes __ Psycho-Social
__ Telephone & Written Communication __ Treatment Plans
This protected health information is disclosed for the following purposes:
__ Referral to other services __ Coordination of Care __ Verbal Communication __ Transfer of Care __Consultation
__ Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.
_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This consent is valid between the following dates: _____ until _____.
I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

_____ _____ _____ _____
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

OR

_____ _____ _____ _____
Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

☐ An individual who cannot write has provided verbal consent, and two individuals have witnessed consent.

Place sticker here

MS LEGACY - STEPPING STONES PSYCHIATRIC CARE : PRIMARY CARE PHYSICIAN (PCP)

Welcome to MS Legacy - Stepping Stones Psychiatric Care (SSPC).

I (Print Name) _____ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		**Primary Care Physician**	
Name:	MS Legacy – SSPC	**Name:**	
Address:	Emerson Lane #1303	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I acknowledge that I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__ Admission & Intake Data __ Clinical Needs __ Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__ Discharge Plans __ Evaluation Summary __ Lab Reports __ Medication Management __ Progress Notes __ Psycho-Social
__ Telephone & Written Communication __ Treatment Plans

This protected health information is disclosed for the following purposes:

__ Referral to other services __ Coordination of Care __ Verbal Communication __ Transfer of Care __Consultation
__ Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization. I acknowledge that SSPC will coordinate with my PCP to facilitate the appropriate delivery of health care services.

This consent is valid between the following dates: _____ until _____.

I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

_____ _____ _____ _____

Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

OR

_____ _____ _____ _____

Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

☐ An individual who cannot write has provided verbal consent, and two individuals have witnessed consent.

Place sticker here

MS LEGACY - STEPPING STONES PSYCHIATRIC CARE : PHARMACY

Welcome to MS Legacy - Stepping Stones Psychiatric Care (SSPC).

I (Print Name) ________________________________ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Pharmacy	
Name:	MS Legacy – SSPC	**Name:**	
Address:	Emerson Lane #1303	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I (Print Name) ________________________________ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Pharmacy	
Name:	MS Legacy – SSPC	**Name:**	
Address:	Emerson Lane #1303	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I (Print Name) ________________________________ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Pharmacy	
Name:	MS Legacy – SSPC	**Name:**	
Address:	Emerson Lane #1303	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__ Admission & Intake Data __ Clinical Needs __ Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__ Discharge Plans __ Evaluation Summary __ Lab Reports __ Medication Management __ Progress Notes __ Psycho-Social
__ Telephone & Written Communication __ Treatment Plans

This protected health information is disclosed for the following purposes:

__ Referral to other services __ Coordination of Care __ Verbal Communication __ Transfer of Care __Consultation
__ Other: ____

This consent is valid between the following dates: ________________________ until ________________________.
I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

________________________________ ___________ ________________________________ ___________
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

OR

________________________________ ___________ ________________________________ ___________
Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

☐ An individual who cannot write has provided verbal consent, and two individuals have witnessed consent.

Place sticker here

MS LEGACY - STEPPING STONES PSYCHIATRIC CARE : INSURANCE COMPANY

Welcome to MS Legacy - Stepping Stones Psychiatric Care (SSPC).

I (Print Name) _____ hearby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		**Insurance Company**	
Name:	MS Legacy – SSPC	**Insurance:**	
Address:	Emerson Lane #1303	**ID # :**	
City/State/Zip:	Bridgeville PA 15017	**Group # :**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	
		Cardholder Name/DOB:	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:
__ Admission & Intake Data __ Clinical Needs __ Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__ Discharge Plans __ Evaluation Summary __ Lab Reports __ Medication Management __ Progress Notes __ Psycho-Social
__ Telephone & Written Communication __ Treatment Plans
This protected health information is disclosed for the following purposes:
__ Referral to other services __ Coordination of Care __ Verbal Communication __ Transfer of Care __Consultation
__ Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.
_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This consent is valid between the following dates: _____ until _____.
I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

_____ _____ _____ _____
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

OR

_____ _____ _____ _____
Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

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FINANCIAL AGREEMENT

Muhammad I. Shaikh, M.D. is a private practice psychiatric practice that accepts most major insurance companies and self-pay patients. It is the responsibility of the patient to verify outpatient mental health coverage for your specific policy to ensure coverage for your services.

Highmark – Blue Cross Blue Shield – UPMC – Self Pay

- Co-payment or balances are due in full at time of service.
- Special financial arrangements must be discussed prior to your appointment.
- Parents/Guardians are financially responsible for payment for services provided to minors, or other legal dependents.

Payment for Services:

Every effort is made to ensure your insurance company makes payment. However, they make the final determination. I agree that I will be responsible for any services received that are not covered or denied by my insurance plan. _____ (initial)

I will provide full and accurate insurance information in advance of my appointment and bring my insurance card at the time of my appointment. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party. I understand that if my insurance company has not responded after 90 days, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives. I understand that I am responsible for payment of any balances on my account. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

Fee Scale:

Psychotherapy	$90
Medication Check	$110
Psychiatric Diagnostic Evaluation	$220
Therapy Initial Assessment	$110
Document/Record Preparation	$25
Return Check Fee	$25
No Show Fee	$40

Policy for Missed Appointments and Cancellations:

Appointment times are reserved exclusively for you; if you do not cancel your appointment, you will be charged $40.00 for the scheduled time. To avoid any missed appointment or cancellation fees, please call 24 hours in advance to make any changes to your appointment. I understand that I must give proper notification to cancel an appointment to avoid any late cancellation or missed appointment fees. I agree to call at least **24** hours in advance to cancel or change my appointment. For Monday appointments, I will call the previous Friday by noon.

Your signature verifies your understanding of the financial responsibility you may have for services rendered during your course of treatment.

_____ _____

PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____

SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____

Staff Signature Date

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stepping stones psychiatric care

Consent for Treatment

Please read the following information regarding the agreement between the healthcare provider, and the patient. Please initial each section, your initials constitute that you accept the policy in this agreement.

I, _____, (Patient/Guardian) request treatment for myself or for the individual for whom I am the legal representative at MS Legacy which may include diagnostic evaluation, psychotherapy, medication management, and treatment for any medical, emotional, and behavioral problems which may be found to exist. The treatment was explained to me in detail and I understand that I must communicate freely with my psychiatrist and/or counselor and not withhold pertinent information regarding my health so that the best course of treatment can be prescribed.

Patient Rights

I certify that I have reviewed a copy of my rights as a patient of Stepping Stones Psychiatric Care. Any questions regarding those rights have been address with staff. **Initial Here**_____

Liability

In consideration of services rendered, Client agrees to hold MS Legacy, blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold MS Legacy free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical care is needed, MS Legacy is not required to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client will assume all liability for any medical expenses, hospital care, or other expenditures without liability to MS Legacy. **Initial Here**_____

Request for Records

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. Records are copied at $25 plus postage and billed directly to you. Please allow two weeks for this request to be processed. **Initial Here**_____

Letters

Letters and forms are often requested by patients (or their parents) to be sent to schools, employers, etc. We do not complete forms for Disability. **Initial Here**_____

Prescriptions & Refills

MS Legacy requires 7 calendar days of notice for medication refills due to special circumstances; as our Benzodide Agreement states, patients need to be seen to receive medication refills . Without notification within 7 days, MS Legacy cannot guarantee that refills will be received by the pharmacy in time to prevent the medication from running out. MS Legacy will not provide new prescriptions if the originals are reported lost, stolen, or are not filled before the expiration date. **Initial Here**_____

Confidentiality

I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency, suspected child or elder abuse or neglect, or risk of harm to self or others. Your confidentiality and privacy are protected by the following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA). **Initial Here**_____

Discrimination Policy

No person will be discriminated upon based on gender, race, religion, age, national origin, disability (mental or physical), sexual orientation, sexual preference, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected, or any other characteristic. Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. **Initial Here**_____

Place sticker here

Permission to Leave Voice Messages
Initialing here gives permission for MS Legacy to leave voicemail message regarding appointments and other necessary information. Discretion will be used in disclosing sensitive materials through voicemail communication. Please initial here to give permission to leave voicemail messages. **Initial Here**_____

Involuntary Termination of Treatment
Multiple causes for involuntary discharge exist. Causes for involuntary termination include, but are not limited to: verbal/physical aggression towards staff members or other patients, harassment of staff members or other patients, threats towards others, illegal activity related to treatment, and destruction of property. If MS Legacy receives information that a patient is receiving prescriptions by other doctors than those with MS Legacy, MS Legacy reserves the right to terminate treatment immediately and involuntarily. If a patient misses any 3 appointments (with the therapist or psychiatrist) within any 4 month span of time, MS Legacy reserves the right to terminate treatment. All patients that receive an involuntary termination of treatment will be provided with written notice and referrals for continued treatment. **Initial Here**_____

Consent for Treatment and Consultation
I authorize and request that Muhammad I. Shaikh, M.D. and MS Legacy to carry out behavioral health treatments, and/or diagnostic procedures that now or during the course of my care as advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above.

I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT a copy:

_____ _____
PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____
Staff Signature Date

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BILL OF RIGHTS

As a client receiving services from MS Legacy, your Client Bill of Rights will include:

You have a right to be treated with dignity and respect.

1. You have the right to unrestricted and private communications inside and outside this facility including the right to make complaints and have your complaints heard and adjudicated promptly.
2. You have the right to participate in the development and review of your treatment plan.
3. You have the right not to be subjected to any harsh or unusual treatment.
4. You have the right to be informed of diagnostic and treatment procedures, their risks and their costs, that are available to you and which would aid in your recovery from mental illness. You have the right to be informed of the reasons and factors involved in recommending a procedure of choice.
5. You have the right to be informed of the nature of material about to be released to others (or obtained) when you are requested to sign a release of information.
6. You have a right to have your records treated in a confidential manner in compliance with the laws of the Commonwealth of Pennsylvania.
7. You have the right to courteous treatment from staff at all times.
8. You have the right to be kept safe from injury while in the auspices of the practice.
9. You have the right to voice complaints or appeals about the insurance company or the care provider.

I (we) have received from MS Legacy staff a clear explanation of my (our) rights in simplest terms. I (we) have received a written copy of these rights. I (we) acknowledge a clear understanding of my (our) rights.

_____ _____

PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____

SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____

Staff Signature Date

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Patient Agreement Form

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____ (names of medication(s) may cause addiction and is only one part of the treatment for_____ (name of condition-e.g., anxiety, depression, etc.).

The goals of this medications are to improve my ability to work and function at home and to assist with managing symptoms.

I have been informed that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly, and I could become sleepy and risk personal injury or death.
2. I may get addicted to this medication.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher risk of addiction.
4. If I need to stop this medication, I must do so slowly, or I may get very sick.

I agree to the following:

- I am responsible for my medications. I will not share, sell or trade my medication. I ill not take anyone else's medications.
- I will not increase my medication until I speak with my doctor.
- My medication will not be replaced if it is lost, stolen, or used up sooner than prescribed.
- I will keep all appointments set up with my doctor and other healthcare providers (e.g. therapist, substance abuse treatment).
- I will bring the pill bottles with any remaining pills of my medication to each visit with the doctor.
- I agree to give a urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours-Monday through Thursday, 9:00AM-6:00PM and Fridays 9:00AM-3:00PM. No refills will be made on nights, holidays or weekends. **I must call at least three (3) working days ahead** (M-F) to request a refill on my medication. **No exceptions will be made.**

I must keep track of my medication. No early or emergency refills will be made.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medication (e.g. a dentist, ER doctor or a hospital) I must inform the doctor as soon as possible.

Privacy

While I am taking this medication, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medication. I will be asked to sign a release for consent to collaborate.

_____ _____

Patient's Signature Date

_____ _____

Physician's Signature Date

_____ This document has been discussed with and signed by the physician and patient. (A signed copy has been given to the patient).