LOTUS
PSYCHIATRY & WELLNESS

4545 42nd St NW, Suite 202
Washington, DC 20016
P: 240-428-4834 F: 888-488-5658

New Patient Registration

Please either e-mail the completed forms to lotuspsychiatry@gmail.com PRIOR to your new patient appointment.

Patient Information

Name: _____ Date of Birth: _____
Address: _____ Phone: (_____) _____ - _____
City: _____ State: _____ Zip: _____ Email: _____

Current Health Providers

PCP: _____ Phone: (_____) _____ - _____
OB/Gyn: _____ Phone: (_____) _____ - _____
Therapist: _____ Phone: (_____) _____ - _____
Other: _____ Phone: (_____) _____ - _____

Medications/Pharmacy

Current Medications: _____ Allergies: _____
_____ _____
Pharmacy Name/Address: _____

Emergency Contact

Name: _____ Phone: (_____) _____ - _____
Relationship: _____

Insurance

Insurance Carrier: _____ Member ID/Policy Number: _____
Group ID Number: _____ RxBIN (if applicable): _____

Information provided will expedite care if prior authorization for prescription medication is required

I voluntarily consent to treatment and understand that I have the right to make informed decisions regarding my care. I understand that I am responsible for payment for psychiatric services rendered at the time of my appointment. I understand I am responsible for the full cost of any appointments unless I give notice of cancellation at least two full business days before the appointment.

I have read the Lotus Psychiatry & Wellness Policies and Procedures. I understand that I will have the opportunity to discuss any questions or concerns. I agree to comply with the office policies as written. I acknowledge that I have received or declined the Notice of Privacy Practices. I understand this notice is available for me to keep.

_____ _____
Patient Signature Date

_____
Printed Name

Communication Consent Form

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After reading the Lotus Psychiatry & Wellness Notice of E-mail Practices, I authorize Lotus Psychiatry & Wellness to:

☑ Send me automatic appointment reminders via E-mail and SMS text messaging through the Practice Fusion platform

☑ E-mail me information or documents which DO NOT contain any identifiers or sensitive health information (i.e., medical information sheets, empty forms, consent forms, etc.)

☑ E-mail me information or documents which DO contain patient identifiers and/or sensitive health information (i.e., invitations for telepsychiatry appointments, completed insurance forms or disability forms, letters for work or school, lab results, bills or invoices, etc.) only after I have verbally discussed this with my provider at Lotus Psychiatry & Wellness

I acknowledge that I have been provided with the Lotus Psychiatry & Wellness Notice of Communication Practices. By signing this consent form, I accept the following:

1. I understand the risks associated with communication via E-mail between Lotus Psychiatry & Wellness and me, and I consent to the conditions and guidelines outlined in the Lotus Psychiatry & Wellness Notice of E-mail Practices, as well as any other instructions that Lotus Psychiatry & Wellness may impose regarding communication.
2. I understand that any E-mail voluntarily sent by me to Lotus Psychiatry & Wellness will not be encrypted and there for the confidentiality of such communications may be breached by a third party.
3. I understand that I may opt out of automatic appointment reminders at any time.
4. I understand that I may alter these communication permissions at any time by updating this consent form and that only the most recent consent form signed will be in effect.
5. I understand that this consent will remain in effect until terminated in writing either by myself or by Lotus Psychiatry & Wellness.
6. I understand that if I have any questions, I may inquire with Lotus Psychiatry & Wellness.

_____ _____

Patient Signature Date

_____

Printed Name

Credit Card Authorization Form

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It is the policy of Lotus Psychiatry & Wellness to keep a credit card on file for all patients.

I, _____, hereby authorize Lotus Psychiatry & Wellness to keep this form and my signature on file and charge my credit card the full amount for any of the following:

1. Appointments that I do not cancel before two full business days of the scheduled appointment
2. Initial evaluations, follow-up appointments, psychotherapy or any other services for which payment was not processed at the time the service was rendered
3. Additional or future services that I verbally approve

Cardholder Name: _____
(name as it appears on credit card)

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover

Credit Card Number: _____ Exp Date: _____

Billing Address: _____ CVV Code: _____

City: _____ State: _____ Zip Code: _____

I agree not to dispute charges for any of the terms outlined above.

I understand the terms of this form and agree that it is valid for five (5) years unless treatment is terminated or I cancel this authorization through written communication with my provider at Lotus Psychiatry & Wellness.

_____ _____
Cardholder Signature Date

_____
Printed Name

Medical Information Release Form

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☐ I **DO** authorize Lotus Psychiatry & Wellness to do the following with my protected health information (please check all that apply):

__ Disclose/obtain protected healthcare information to/from individuals/entities listed below

__ Provide/receive a complete copy of my healthcare records to/from those individuals/entities listed below

__ Provide/receive only part of my healthcare records to those individuals/entities listed below
Information to be limited to: _____

Name/Entity: _____ Name/Entity: _____

Address: _____ Address: _____

_____ _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

☐ I **DO NOT** authorize Lotus Psychiatry & Wellness to release any protected health information at this time. I understand that I may authorize the release of protected health information at any time by completing a new Medical Information Release Form.

I understand that any authorization I give on this form is valid for one year from the date signed, unless I revoke or withdraw this authorization through written communication to my provider at Lotus Psychiatry & Wellness or unless an earlier date is specified here: _____.

I understand that the medical information released may contain information sensitive information such as HIV/AIDS status, sexually transmitted diseases, mental health, and drug and alcohol abuse.

I understand that once my healthcare information is disclosed at my request, it may no longer be protected under federal and state privacy laws and could be re-disclosed by the person or entity receiving it.

I understand that there may be a fee for a copy or written treatment summary of my healthcare information. I understand that all fees will be in compliance with applicable law. I agree to pay this fee.

_____ _____

Patient Signature Date

_____

Printed Name

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Policies & Procedures

INITIAL CONSULTATION & CONSENT TO ENGAGE IN TREATMENT

All initial appointments at Lotus Psychiatry & Wellness are consultation appointments. Providers will perform a full evaluation and give feedback regarding the evaluation and any recommended treatment plan. The consultation is designed so that the provider and patient can determine by the end of the initial appointment if they would like to continue working together. If so, the provider at Lotus Psychiatry & Wellness will become the patient's treating psychiatrist. If, at any point during treatment, the provider or the patient determines that the patient would be better served by receiving treatment from a different provider, this will be discussed, and referrals will be provided to the patient.

BILLING & PAYMENTS

Payment is due in full at the time of service via credit card or cash. We accept Visa, MasterCard, American Express, and Discover. Lotus Psychiatry & Wellness is an "out-of-network" provider and is unable to file claims directly with insurance as a form of payment. Patients with health insurance will need to pay out-of-pocket at the time service and are encouraged to submit claims to their insurance and utilize any out-of-network benefits. All patients will be provided with a specialized invoice at the time of payment that contains all information necessary to submit claims for out-of-network reimbursement.

APPOINTMENTS & CANCELLATIONS

Patients are financially responsible for all services scheduled with Lotus Psychiatry & Wellness. If a patient would like to cancel an appointment, notice must be given within two full business days (48 hours excluding weekends and holidays) prior to the appointment. Any cancellations received after this time will be subject to charge for the full session. Please note that insurance plans do not reimburse for missed appointments.

Patients arriving late to appointments will be subject to charge for the full session. Patients who arrive with less than 10 minutes remaining in the appointment will not be seen. The patient will be charged for the full session, and a new appointment will need to be scheduled.

MEDICATION REFILLS

When calling about a refill, please leave your name, date of birth and phone number, along with the medications requested, their dosages, and the phone number of your pharmacy. If accepted by the provider, please allow 2-3 business days for medications to be refilled.

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CONFIDENTIALITY

All information shared with Lotus Psychiatry & Wellness will be kept confidential as mandated by HIPAA. Providers may share certain information with a third party only with the express written agreement and consent of the patient AND if the provider deems that doing so is in line with the patient's treatment plan. There are some situations in which providers at Lotus Psychiatry and Wellness may legally be required to take action that could include revealing some information about the patient's treatment. Examples of such situations include imminent risk/threat of self-harm (patient), imminent risk/threat of harm to others, and child or elder abuse. Please refer to the Lotus Psychiatry & Wellness Notice of Privacy Practices document for full details on all privacy practices. A copy of privacy practices is given to all new patients and is also available upon request.

CONTACT INFORMATION

Contact your provider at Lotus Psychiatry & Wellness at 240-428-4834, and your call will be returned at our earliest convenience within one business day. Providers at Lotus Psychiatry & Wellness do not use text messages or e-mail to communicate to patients outside of automatic appointment reminders. Phone calls that require more than a quick response will be charged at our prorated hourly rate. **In the event of a medical or psychiatric emergency, please call 911 or go to your nearest emergency room.**

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Notice of E-mail Practices

Lotus Psychiatry & Wellness routinely sends appointment reminders to a patient's e-mail through Practice Fusion, Lotus Psychiatry & Wellness' electronic medical record system that uses an encrypted server. It is our general policy that all other communications between patients and providers at Lotus Psychiatry & Wellness be conducted either in person or over the phone to ensure and maintain HIPAA standards of confidentiality. However, there are times when a patient may wish to use e-mail as an alternative form of communication. The patient has a right to request the use of e-mail as an alternative form of communication as long as the patient is made aware of the risks associated with using e-mail.

RISK OF USING E-MAIL

The transmission of patient information by e-mail has several risks that patients should consider before the use of e-mail. These include, but are not limited to, the following risks:

1. E-mail can be circulated, forwarded, stored electronically and on paper, and broadcast to unintended recipients.
2. E-mail senders can easily misaddress an e-mail and send the information to an undesired recipient.
3. Backup copies of e-mail may exist even after the sender and/or the recipient has deleted his/her/their text.
4. Employers and online services have a right to inspect e-mail sent through their company systems.
5. E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
6. E-mail can be used as evidence in court.
7. E-mail may not be secure, and therefore the confidentiality of such communications may be breached by a third party.

CONDITIONS FOR THE USE OF E-MAIL

Lotus Psychiatry & Wellness cannot guarantee but will use reasonable means to maintain the security and confidentiality of all information sent and received. Lotus Psychiatry & Wellness is not liable for improper disclosure of confidential information that is not caused by Lotus Psychiatry & Wellness' intentional misconduct. Patients must acknowledge and consent to the following conditions:

1. E-mail is not appropriate for urgent or emergency situations. Lotus Psychiatry & Wellness cannot guarantee that any particular e-mail will be read and responded to within any specific timeframe.
2. As Lotus Psychiatry & Wellness provides mental health services, communication via e-mail outside of automatic appointment reminders will need to be discussed and will be used on a case-by-case basis. In general, it is the policy of Lotus Psychiatry & Wellness not to use e-mail to discuss or address clinical issues (i.e., changes in symptoms, problems with medications).
3. All clinically relevant e-mail will be printed and filed into the client's medical record per the physician's discretion.

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4. Lotus Psychiatry & Wellness will not forward patient-identifiable e-mails without the patient's written consent, except as authorized by law.
5. Lotus Psychiatry & Wellness is not liable for breaches of confidentiality caused by the client or any third party.
6. Any e-mail consent signed by the patient will remain in effect until terminated in writing either by myself or by Lotus Psychiatry & Wellness.
7. In the event that the patient does not comply with the conditions herein, Lotus Psychiatry & Wellness may terminate the patient's privilege to communicate by e-mail with Lotus Psychiatry & Wellness.

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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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Responsibilities

Your protected health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination, test results, diagnoses, and treatments. It also includes payment information related to your care. The law requires us to keep your health information private in accordance with this Notice of Privacy Practices. We are also required to provide you with a copy of this document, which contains our privacy practices, our legal responsibilities, and your rights concerning your health information.

Permitted Uses and Disclosures

Under federal law, we may use and disclose your health information without authorization for treatment, payment, or health care operations. Examples of such potential uses or disclosures are provided below:

- Treatment
  Your health information may be used by or disclosed to any physicians or other health care providers involved with the medical services being provided to you. We may also use your health information to manage or coordinate your treatment.
- Payment
  Your health information may be used or disclosed to collect payment for the medical services provided to you.
- Health Care Operations
  Your health information may be used or disclosed as part of our internal health care operations, such as quality of care audits, training programs, accreditation, certification, licensing, or credentialing activities.

Other Uses and Disclosures without Authorization

While the following disclosures can be made without your consent or authorization, we will make our best effort to inform you when disclosure is being made or there is an intention to do so.

- Abuse, Neglect, or Domestic Violence
  As required by law, we may disclose your health information to report suspected abuse, neglect, or domestic violence.

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- Judicial and Administrative Proceedings
  We may disclose your health information in the course of a judicial or administrative proceeding, in response to a subpoena or other orders required by law.
- Notification
  We may use or disclose your health information to notify a family member or other person identified by you who is involved in your care about your location, about your general condition, or your death. We will provide you an opportunity to object before disclosing any such information.
- Public Safety
  We may disclose your health information for public health purposes, such as a serious and imminent threat to the health or safety of a person or the public.
- Required by Law
  We may be required by federal, state, or local law to disclose your health information.
- Third-party
  We may disclose your health information to third parties with whom we contract to perform services on our behalf. If we do so, we will have an agreement with them to safeguard your information.

We will not disclose your health information for any reason except those described in this Notice of Privacy Practices unless you provide us with written authorization to do so. We may request authorization to use or disclose your health information for any purpose; however, you are not required to give authorization as a condition of your treatment. You may revoke any written authorization in writing at any time, but such revocation will not affect any prior authorized uses or disclosures.

Patient Rights

You have the following rights concerning your protected health information:

- Requesting Restrictions
  You have the right to request a restriction on limiting our use and disclosure of your health information. We are not required to agree to your request, but if we do agree to it, we will abide by your request except as required by law, in emergencies, or when the information is necessary to treat you. To request a restriction, it must: 1) be in writing 2) describe the information that you want to restrict 3) state if the restriction is limited to use or disclosure and 4) state to whom the restriction applies.

- Confidential Communications
  You have the right to request that we communicate with you about your health information in a

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particular way or at a specific location, to maintain your confidentiality. To request confidential communication, it must: 1) be in writing and 2) specify how or where you wish to be contacted. We will accommodate all reasonable requests. You do not have to give a reason for your request.

- Inspect and Copy
  You have the right to inspect and obtain a copy of your health information. To request to inspect or obtain a copy of your health records, it must be in writing. We may charge a fee for record retrieval, copying costs, mailing, and other supplies.
- Amendment of Health Information
  You have the right to request amendment of your health information if you believe that it is incorrect or incomplete. To request an amendment, it must: 1) be in writing and 2) include a reason to support your amendment request. Your request may be denied if it was not created by us, if we believe that the information is complete and accurate or if the information is not part of the medical information that you would be permitted to inspect or copy.
- Accounting of Disclosure:
  Under federal law, you have the right to request a list of the disclosures that we have made of your health information over the previous six years. This right applies to disclosures other than treatment, payment, or healthcare operations as described in this Notice of Privacy Practices. Your first request within a 12-month period is free, but we may charge for additional lists within the same 12-month period. To request an accounting of disclosure, it must be in writing.
- Paper Copy of This Notice
  You have the right to keep a paper copy of this Notice of Privacy Practices.
- File a Complaint
  If you believe that your privacy rights have been violated, you may file a complaint directly with us in writing. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

This Notice of Privacy Practices and its terms may be revised as permitted or required by law. Lotus Psychiatry & Wellness has the right to make the revised notices effective for information that we already have about you, as well as for information we obtain in the future. The updated Notice of Privacy Practices will be provided to you in paper copy.