The Center for ADHD, Inc.
R. Timothy Brown, MD
Stacey W. Boudoin, APRN, PMHNP-BC
Desiree' Norman, APRN, PMHNP-BC
slidell@centerforadhd.hcpsecure.com

635 Lafitte Street, Suite B
Mandeville, LA 70448
Phone (985) 624-5305
Fax (985) 624-8643

1301 Brownswitch Road, Suite A
Slidell, LA 70461
Phone (985) 649-6475
Fax (985) 649-6476

Consent to Evaluate and Treat

Date: ______________________

Patient: _________________________________ Age: ____________ Date of Birth: ____________________

Female: _______ Male: ________

Black: _______ Hispanic: ____________ White: _____________ Other: ___________

Address: ____

City, State, Zip Code: ____

Home Phone: ____________________________ Work/Cell: ______________________

Address (if different from patient): ____

City, State, Zip Code: ____

Home Phone: __________________________ Work/Cell: ________________________

I authorize the Center for ADHD, Inc. to Evaluate and Treat:

____

Print patient name

Relationship to patient: ________________________________ Date: ________________________

Signature: ____ Date: _________________________

Witness: ____ Date: __________________________

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Financial Policy Agreement

We believe that everyone benefits when there is a clear and definite understanding of our financial policy prior to treatment.

1. **PATIENTS WITHOUT INSURANCE**: All patients without insurance are required to pay in full for the service rendered at the time of the appointment.
2. **ALL PATIENTS WITH MANAGED CARE PLANS**: It is your responsibility to know and understand your managed care plan. Generally, these plans require payment of deductible and/or copayments.Patients are required to pay for services according to their insurance contract at the time of service.
3. **ALL PATIENTS WITH INSURANCE**: If our office is contracted with your primary insurance company, we will file your primary insurance claims if you provide us with the proper information along with a copy of your current insurance card. In the event your insurance overpays, we will refund the overpayments to you promptly upon written request. Otherwise, overpayments will be credited to your account for future services. If your insurance company does not pay within 60 days, you are responsible for the remaining balance and you will be billed accordingly.
4. **CANCELLATION POLICY**: There is a **$125** charge for failed appointments/late cancellations of appointments then less than a **24-hour notice** is given by the patients. There is an answering machine for after-hour needs. You will be charged the full fee for the service which would have been rendered.

Reminder calls/texts to our patients are offered as a courtesy.

5. **QUESTIONS**: You are encouraged to call our office if there are any questions about this information. If at any time during treatment of the patient, financial problems arise, you are encouraged to speak with our office.
6. Payment for services rendered may be made by check, cash or credit card (Master Card or Visa)

I have read and agree with the terms of this agreement.

Responsible Party Signature: ________________________ Date: ________________

ASSIGNMENT OF BENEFITS

I authorize payments of insurance benefits to Center for ADHD, Inc. for all services rendered.

Responsible Party Signature: ________________________ Date: ________________

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CREDIT CARD CONSENT POLICY FORM

I, the undersigned authorize The Center for ADHD, Inc. to keep my signature on file and to charge my credit/debit card account as indicated below:

__________Visa   _________ Mastercard

A charge to the credit/debit card will ONLY be made under the following circumstances:

1. Missed appointments.
2. Cancellations made less than 24 hours from the time of scheduled appointment.
3. Any claims that are denied secondary to insurance not being in effect at the time of service.
4. Any claim that is applied toward a deductible.
5. Any claim that is denied secondary to failure on the part of the patient/patient's responsible party to obtain proper authorization or referral and/or failure to complete forms required by insurance company needed to process claim.
6. Any claim that becomes more than 120 days past due after proper filing and at least 1 refilling by this office.

There will be a $125 fee for any non-cancelled appointment.

I, the undersigned understand that this form will be valid for the duration of my treatment with this office **UNLESS** I cancel through written notice to The Center for ADHD, Inc., 635 Lafitte Street Ste. B Mandeville, Louisiana 70448 or 1301 Brownswitch Road Ste. A Slidell, Louisiana 70461.

____
Patient Name

____
Cardholder Name

____
Cardholder billing address

____
Credit Card Number

Mo:________ Yr. ______
Expiration Date

____
Cardholder Signature

____
Date

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We value you as a patient of my practice and are committed to providing safe and effective mental health services to you. We want to make sure that you are aware of your rights and responsibilities as a patient. We believe that by doing so, you will be able to best work with me and the office staff in your treatment.

AS A PATIENT, YOU HAVE THE RIGHT TO:

- Considerate and courteous care by the office staff and physician.
- Privacy and confidentiality about your care, treatment and records.
- Respect for your time -be greeted upon arrival & kept informed regarding the approximate waiting time.
- A Safe and comfortable environment for your care.
- Complete and current information regarding your diagnosis, treatment and prognosis; the nature and purpose of tests, prescribed therapy and/or medications, and potential adverse effects associated with the treatment plan.
- Clear instructions concerning the need for follow-up visits, referral to other mental health professionals, or additional measures necessary to achieve the desired outcome for your diagnosis.
- Accept or refuse any/all of the treatment plan after receiving a complete explanation.
- Additional professional opinion(s) on any diagnosis or recommended treatment plan.
- A copy of medical records pertaining to your treatment after payment of reasonable copying fees and account balances, if any.
- Information about your account, the amount and purposes of charges and our policies regarding payment of charges as well as procedures for resolving conflicts in the settlement of the account.

AS A PATIENT, YOU HAVE THE RESPONISIBILTY TO:

- Provide correct, complete information about your health.
- Follow the treatment plan ordered by your physician, unless you notify him of concerns.
- Consider the rights of other patients and office personnel.
- Follow office rules and regulations that apply to patient conduct.
- Take responsibility for your actions if you refuse treatment or do not follow your physician's instructions.
- Meet the financial obligations for your care as soon as possible.
- Call the office if unable to keep scheduled appointments and arrive on time for scheduled appointment.

We want to make sure that you are satisfied with the care you receive from your physician and office staff. If you have questions or concerns, you may speak with the office staff or physician.

I acknowledge that I have read and understand this Notice of Privacy Practices.

Patient Name:________________________________ DOB: ______________________

Signature of Patient:__________________________ Date: ______________________

If patient is a minor, Parent/Guardian signature: ______________________________

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In order to bill your insurance, please provide us with the following information. Even if we are not a contracted provider for your plan, we may still need the information if medication authorizations are required.

Please provide the following information:

Patient Name: ____

Patient Address: ____

Date of Birth: ________________ Social Security Number: ____________________

Primary Insurance: ____________________________

Policy ID Number: ____________________________

Group Number: ____________________________

Primary Insurance Phone: ________________________

Policy Holder's Name: ____________________________

Date of Birth: ________________ Social Security Number: ____________________

Policy Holder's Relationship to Patient: ________________________________

Secondary Insurance (if applicable): ______________________________

Policy ID Number: ________________________

Group Number: ______________________

Primary Insurance Phone: ______________________

Policy Holder's Name: ____________________________

Date of Birth: ________________ Social Security Number: ____________________

Policy Holder's Relationship to Patient: ____________________________

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Controlled Substances Treatment Agreement for patients over 18

Stimulant (narcotic) treatment for ADHD is used to decrease your ADHD symptoms and to improve what you are able to do each day. Along with this treatment, other medical care may be prescribed to help improve your ability to do daily activities. This may include exercise, use of non-narcotic medication, psychological counseling or other therapies or treatment.

I, ______________________understand the compliance with the following guidelines is important in continuing ADHD treatment with The Center for ADHD, Inc. I understand that I have the following responsibilities and agree to adhere to all of the following rules while I am under the care of The Center for ADHD, Inc.:

1. I will take medications as prescribed.
2. I will not increase or decrease without the approval of my physician/ APRN.
3. I will not obtain medications from several physicians, but my physician/APRN only. (Under certain circumstances, if I obtain any additional narcotic from other physicians such as primary care physician or emergency room physician, then I will immediately notify The Center for ADHD, Inc.)
4. I will not share the medication with anyone including family members.
5. I will not sell the medication.
6. I will not get replacement for any lost or stolen medication regardless of the circumstance.
7. I will not get early refills.
8. I will notify if I abuse alcohol or use other illicit drugs along with ADHD medication.
9. I agree to periodic random drug screening tests.
10. I agree to periodic random pill counts.
11. I agree to participate in adjunctive management programs such as: psychological testing, counseling therapy, behavioral modification, school-based interventions, job modifications if recommended by the physician/APRN.
12. I will not request prescription refills when the clinic is closed after hours or on weekends.
13. If I am pregnant or intend to get pregnant, I am required to notify The Center for ADHD, Inc. immediately to discuss tapering off stimulants that could potentially harm the fetus. I understand that failure to do so may result in discharge from the clinic. I will not hold the clinic responsible for any harm that may occur to me and/or my unborn.

I, ________________________understand that this physician/APRN may stop prescribing the medication or change the treatment plan if I failed to follow the above recommendations. I have read this document, understand and have had all my questions answered satisfactorily. I consent to the use of stimulants to help control my ADHD and I understand that my treatment with stimulants I will be carried out as described above.

____ ____

Print Patient Name **Patient Signature & Date**

____ ____

Print Witness Name **Witness Signature & Date**

____ ____

Print Physician/APRN Name **Physician/APRN Signature & Date**