Patricia Hurzeler, APRN, BC

Please fill in all shaded items, at least

Intake Date:

Last: First: Middle: Salutation:

Employed Full-Time Student Part-Time Student Single Married Divorced Other

Male Female Birth Month: Day Year

Apt Suite Box: Num And Street: phone:

City: State: Zip: cell phone:

Emergency Contact:

Home phone (Emgcy Contact): Work phone (Emgcy Contact):

Pt's Business:

Businessphone: Ext:

Pharmacy:

Comments:

Insurance

Effective Date (if known): Termination Date if any:

Insurance Co: Plan Code:

ID #: Plan or Program Name:

Phone # on card: CoPay for Mental Health:$

Deductible:$

Member Suffix: Self Spouse Child Other

Info on Primary Insured, if not Self:

Last Name: First: M.I: Employer:

Birth Date:

Address: City: State: Zip:

Phone:

Secondary Payor (if any, e.g. Medigap

Contract ID#: Program Name

Ins.Authorization (if applicable)

Authorization #: Auth Date (req'd): Start Date: End Date:

Comment on Insurance:

(version date 1/21)

Pat Hurzeler APRN, BC

978-225-8059 **PatHelps.com**

Please sign and date:

I, _____ agree to the sharing of information among my care provider(s), listed below:

1. _____ Phone # _____
2. _____ Phone # _____
3. _____ Phone # _____

and with the following family member(s) or friend(s):

1. _____ Phone # _____
2. _____ Phone # _____

and with Pat Hurzeler, APRN, BC for the purposes of coordinating my treatment and planning my medical care.

For Medicare patients: Medicare ID Number: _____
I request payment of authorized Medicare benefits to me or on my behalf for any services furnished me by Patricia Hurzeler. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine these benefits.

I am free to change this agreement at any time. If and when this is necessary, I will do so in writing.

Patient Signature_____

Printed Patient Name_____

Date _____

Provider Copy ☐

Patricia Hurzeler, APRN, BC

PatHelps.com

Patient Name: _____ Date: _____

Please list all your current and chronic health problems:

_____
_____
_____
_____
_____
_____
_____
_____

Please list all your current medications:

_____
_____
_____
_____
_____
_____

Please list all your past medications:

_____
_____
_____
_____
_____
_____

2016 Feb

Patricia Hurzeler, APRN
Advanced Practice Nurse in Psychiatry and Psychopharmacology

978-225-8059 PatHelps.com

Notice of Privacy Practices
Please read, sign, and return Patient Copy ❑

This notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information; in accordance with the Health Insurance Portability and Accountability Act (HIPAA) of 1966.

My commitment to your privacy

My practice is dedicated to maintaining the privacy of your health information. I am required by law to maintain the confidentiality of your health information.

I realize that these laws are complicated, but I must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances: I may be required to use or disclose your health information:

1. To **public health** authorities and **health oversight** agencies that are authorized by **law** to collect information
2. In response to **lawsuits** and similar proceedings in response to a **court** or **administrative** order
3. If required to do so by a **law enforcement official**
4. When necessary to reduce or prevent a serious **threat** to your **health and safety** or the health and safety of another individual or the public. I will make disclosures **only** to a person or organization able to help **prevent** the threat.
5. If required by the **appropriate authorities** and if you are a member of the U.S. or foreign **military forces** (including veterans).
6. To federal officials for **intelligence** and national **security** activities authorized by **law**.
7. To **correctional institutions** or **law enforcement** officials if you are an **inmate** or under the **custody** of a law enforcement official.
8. For **Workers Compensation** and similar programs.

Your rights regarding your health information

1. Communications: You can request that my practice communicate with you about your health and related issues in a **particular manner** or at a **certain location**. For instance, you may ask that I contact you at home, rather than at work. I will accommodate reasonable requests.
2. You can request a **restriction** in my use or disclosure of your health information for **treatment, payment, or health care** operations. Additionally, you have the right to request that I **restrict** my **disclosure** of your health information to **only certain individuals** involved in your care or the payment of your care, such as family members and friends. I am **not** required to agree to your request; however if we do agree I am **bound** by our agreement **except** when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to **obtain** and **inspect** a copy of the health information that may be used to make decisions about you, including patient **medical records** and **billing records**, but **not** including **psychotherapy** notes. You must submit your request in **writing** to Patricia Hurzeler, APRN.
4. You may ask me to **amend** your health information if you believe it is **incorrect** or **incomplete**, and **as long as** the information is kept by or for my practice. Your request for an amendment must be made in **writing** to Patricia Hurzeler, APRN and must **include** the **reason** that supports your request for amendment.
5. Right to copy of this notice: You are entitled to receive a copy of the Notice of Privacy Practices. You may ask me to give you a copy of this Notice at any time. To obtain a copy of this notice, contact Patricia Hurzeler APRN.
6. Right to file a **complaint**: If you believe that your **privacy rights** have been **violated**, you may **file** a **complaint** with my practice **or** with the Secretary of the Department of Health and Human Services. To file a complaint with my practice, **contact** Patricia Hurzeler APRN. All complaints must be submitted in **writing**. You will **not** be penalized for filing a complaint.
7. Right to provide an authorization for other uses and disclosures: My practice will obtain **written authorization** for uses and disclosures that are **not identified** by this notice or permitted by applicable law.

If you have any questions regarding this notice or my health information privacy policies, please contact Patricia Hurzeler APRN.

I hereby acknowledge that I have been presented with a copy of the Patricia Hurzeler APRN Notice of Privacy Practices.

Signed _____

Date _____

Medical information may be released to your insurance company at their request.

Patricia Hurzeler, APRN
Advanced Practice Nurse in Psychiatry and Psychopharmacology

978-225-8059 PatHelps.com

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4. When necessary to reduce or prevent a serious **threat** to your **health and safety** or the health and safety of another individual or the public. I will make disclosures **only** to a person or organization able to help **prevent** the threat.
5. If required by the **appropriate authorities** and if you are a member of the U.S. or foreign **military forces** (including veterans).
6. To federal officials for **intelligence** and national **security** activities authorized by **law**.
7. To **correctional institutions** or **law enforcement** officials if you are an **inmate** or under the **custody** of a law enforcement official.
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Signed _____

Date _____

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PrivacyPolicy201409

A Shared Decision-Making Practice

A Patient and Nurse-Practitioner **Working Agreement** for the **Best** Possible **Outcomes**

1. I am trained and licensed to offer you **standard-of-practice** choices in mental health care.

2. I offer you treatment options consistent with **current psychiatric standards**. Unfortunately, black-and-white options are rarely available. I will try to offer more than one safe treatment option, per your requests.

3. You are **free to make decisions** based on my input, the input of other professionals, your own research, and your values. You are free to ignore my input.

4. Regarding **Prescriptions:**
   - Please ask for refills during appointments.
   - I do not replace lost or stolen prescriptions for controlled substances, or refill them early.
   - If you must leave me a voicemail on 978-225-8059 asking for a **refill**:
     - Include your name, the medication name, exact dose, and **pharmacy phone number**.
     - Expect up to a 1 week wait. Check with the pharmacy.
     - I can not refill prescriptions for **controlled substances** by phone, only **during appointments.**
   - I am **not** available 24/7, nor on **weekends** nor **holidays** for refills. Act before you are running low.
   - I do not fulfill refill requests made through a pharmacy. Contact me directly.
   - Prescriptions cannot be refilled indefinitely; we must meet face-to-face every 2-4 months. Call for an **appointment to renew** if needed.
   - Avoid last-minute **holiday crunches**- plan ahead!
   - Running out of psychiatric medications is rarely an emergency. If you have concerns, speak with me beforehand.

5. I cannot answer the **telephone**. I have no secretary. Leave me a **confidential voice mail** at 978-225-8059.
   - For any insurance plan that requires authorization from a primary care physician (HMO), it is your responsibility to ensure that I receive all necessary referrals prior to treatment. You are responsible for any charges denied by the insurance carrier due to lack of referral.
   - I do not discuss clinical, medical, or psychological issues by phone; only logistics such as appointments and prescription fulfillment.
   - You can **not** reach me by **texting** or **email**.

6. I will post my **vacation** times on PatHelps.com so you can **plan** ahead for your needs.

7. If you have a psychiatric **emergency**, you must go to your nearest Emergency Room.

8. Regarding your Insurance or Benefit Plans:
   - For any insurance plan that requires authorization from a primary care physician (HMO), it is your responsibility to ensure that I receive all necessary referrals prior to treatment. You are responsible for any charges denied by the insurance carrier due to lack of referral.
   - You are responsible for knowing your insurance coverage and its limitations. The insurance contract is between YOU and your insurance carrier.
   - You understand and agree that your insurance carrier will pay Patricia, not you, for services rendered. You agree that you are responsible for any deductibles, copays, coinsurance, or denials.

--continued on the other side of this sheet---

Your **Responsibilities** for the **Best** Possible Treatment **Outcomes**

1. **Inform me fully** regarding history, symptoms, previous treatments, and outcomes.

2. **Report difficulties** with following your medical plan, use of substitutions, and other health factors.

3. Come to your appointments **on time** whether or not you receive a reminder call. I charge $100 for **broken appointments** when not given **48 hours** notice. This is **not covered** by your insurance company.

4. Call your insurance carrier **before** your visit and obtain any Authorization required by your policy.

5. By signing below, you **agree to pay** any copays, co-insurance, deductibles or other non-covered charges.

I cannot be effective with your care if you don't **keep appointments** or don't **take your medications** as prescribed. If you are not honest with me or are abusive in any way, I will ask you to seek treatment elsewhere.

I am unwilling to work with patients who keep **guns** at home. Your signature below attests that you do not have access to any guns. I am willing to discuss this decision with you.

To acknowledge that you have read, understood, and agreed to these principles, please sign and date below:

Patient Signature _____ Printed Name _____

Guardian Signature _____ Guardian's Printed Name _____

Date _____

Working Agreement 09/19/2019

A Shared Decision-Making Practice

A Patient and Nurse-Practitioner **Working Agreement** for the **Best** Possible **Outcomes**

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   - If you must leave me a voicemail on 978-225-8059 asking for a **refill**:
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     - Expect up to a 1 week wait. Check with the pharmacy.
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   - I am **not** available 24/7, nor on **weekends** nor **holidays** for refills. Act before you are running low.
   - I do not fulfill refill requests made through a pharmacy. Contact me directly.
   - Prescriptions cannot be refilled indefinitely; we must meet face-to-face every 2-4 months. Call for an **appointment to renew** if needed.
   - Avoid last-minute **holiday crunches**- plan ahead!
   - Running out of psychiatric medications is rarely an emergency. If you have concerns, speak with me beforehand.

5. I cannot answer the **telephone**. I have no secretary. Leave me a **confidential voice mail** at 978-225-8059.
   - For any insurance plan that requires authorization from a primary care physician (HMO), it is your responsibility to ensure that I receive all necessary referrals prior to treatment. You are responsible for any charges denied by the insurance carrier due to lack of referral.
   - I do not discuss clinical, medical, or psychological issues by phone; only logistics such as appointments and prescription fulfillment.
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   - For any insurance plan that requires authorization from a primary care physician (HMO), it is your responsibility to ensure that I receive all necessary referrals prior to treatment. You are responsible for any charges denied by the insurance carrier due to lack of referral.
   - You are responsible for knowing your insurance coverage and its limitations. The insurance contract is between YOU and your insurance carrier.
   - You understand and agree that your insurance carrier will pay Patricia, not you, for services rendered. You agree that you are responsible for any deductibles, copays, coinsurance, or denials.

--continued on the other side of this sheet---

Your **Responsibilities** for the **Best** Possible Treatment **Outcomes**

1. **Inform me fully** regarding history, symptoms, previous treatments, and outcomes.

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To acknowledge that you have read, understood, and agreed to these principles, please sign and date below:

Patient Signature _____ Printed Name _____

Guardian Signature _____ Guardian's Printed Name _____

Date _____

Working Agreement 09/19/2019

Credit Card Authorization

I acknowledge that co-payments are due at the time of my appointment. My health insurance company may reimburse you for my treatment; however I am responsible for any deductible, co-payment, co-insurance, or other balance applicable to my individual policy.

By submitting the credit card authorization below, I give you permission to collect any such balances owed.

CREDIT CARD AUTHORIZATION FORM

Client Name: (please print)	
Cardholder Name: (if different from client name)	
Type of Card:	Visa □ Master Card □ Discover □ Debit Card □
Credit Card #:	
Expiration Date:	
3-digit security code (on back of card)	
City, State, ZIP (where credit card bill is mailed)	
Phone Number:	
Email address:	
Date:	

I will notify you when any of this information changes.

Client Signature _____