825 DILIGENCE DRIVE, SUITE 100 & 206 **PHONE: 757-310-6900**

NEWPORT NEWS VA, 23606 **FAX: 757-240-5936**

Welcome to Coastal Medical and Psychiatric Services

The CMPS Team is dedicated to promoting professional values and ethics in the practice of psychiatry, as well as access to the highest quality of medical care through support of education and advocacy for our profession, our patients, and their families. We strive to provide a comprehensive selection of professional services. This includes medication management for children, adolescents, and adults, psychotherapy to assist individuals, couples, and groups in meeting life challenges and play therapy to encourage the unique development and emotional growth of children.

SERVICES

We currently provide treatment by board certified Nurse Practitioners, Licensed Clinical Social Workers, and Licensed Professional Counselors. Nurse Practitioners specialize in the diagnosis and treatment of a variety of mental health and psychological disorders. Our LCSW/LPCs are specially trained in individual therapy, crisis intervention, assessment and diagnosis, play therapy, cognitive behavioral therapy and dual-diagnosis work.

An initial appointment is done in order to assess the biological, psychological and social components of the patient, and to decide the appropriate treatment for your specific needs. Recommendations may be made for prescription medications, lab work, or referrals to a specialist for further testing.

APPOINTMENTS

Appointments are scheduled by calling the office. New patients are asked to arrive at least 15 minutes early to their scheduled appointment to complete the new patient paperwork. Established patients are asked to arrive 10 minutes early to scheduled appointments to verify and update any insurance or address information. **YOU WILL BE CHARGED FOR ANY APPOINTMENTS NOT KEPT, UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE.** Your insurance does not cover these charges. The law does not allow us to bill insurance companies for missed appointments; therefore, the patient is fully responsible for any fees due. **Our electronic health records system has appointment reminder capabilities however, appointment reminders, whether they be email or text, are a courtesy, not a guarantee. It is your responsibility to keep track of your scheduled appointments.**

FEES FOR SERVICE

Co-payments must be made at the time of your scheduled visit. If you are unable to pay your payment, you may be asked to reschedule. We accept cash, cards, and checks. We do not accept post-dated checks. Refer to the Financial Policy for further information on fees. Please inform the staff if you would like a copy of your signed Financial Policy consent form.

PHONE HOURS, VOICEMAILS, AND RETURN CALLS

Phone lines are open:
Monday – Thursday 10:00am – 4:30pm
Fridays 10:00am – 2:00pm
Phones are closed from 12:00pm – 1:30pm daily
If you are unable to reach a front desk staff member, please leave a detailed message and your call will be returned in the order in which it was received. All voicemails will be returned by a staff member even if the call is to speak to a provider directly. If a message is left with a provider, your call will be returned within a 24-48 hour period at the end of the work day.

AFTER HOURS ANSWERING SERVICE

Calls outside of normal business hours go to a voicemail. Your provider will be available for emergencies only after regular office hours through our answering service. Calls to the answering service are for emergencies only. Calls to the answering services that are deemed not emergent such as medication refills, medication changes, prior authorizations, scheduling appointments, or billing questions and will generate a $75 fee. This fee is not covered by insurance and will be the patient's responsibility. If your provider is not available, calls may be covered by a colleague. The provider on call may also need access to your patient record in the event of emergencies.

PRESCRIPTIONS

Your provider will always send in enough medications to last you until your follow-up appointment. **Due to the nature of these medications, controlled substances including benzodiazepines and stimulants are filled by appointment only.** Prescriptions that are lost or misplaced in between scheduled appointments may be replaced, at your provider's discretion, for a $10 lost prescription fee. You will need to come to the office to pick them up. Failure to comply with recommended treatment is grounds for termination.

1. Medication must be taken only as prescribed by your provider, and you must notify your provider when medication is given to you by another person or physician.

2. If you are unable to tolerate any medication, please contact the office as soon as possible. If the medication is a controlled substance, you must return the unused portion of the medication before you are given a different prescription.

3. You must not share, sell, or otherwise permit others to have access to these medications. Failure to comply could result in termination from the practice. Accommodations will not be made for patients who are overusing or abusing their prescribed medications.

4. All prescriptions should be filled at the same pharmacy (of your choice). Should the need arise to change pharmacies, you must inform the office.

5. Your prescriber and our staff have permission to discuss diagnostic and treatment details with dispensing pharmacists or your other healthcare providers for the purpose of medication accountability.

PROVIDERS COMPLETED FORMS AND LETTER

Due to additional time required, there is a fee for all forms or letters completed by the providers, if done outside of an appointment. This may include, but is not limited to disability forms, employee forms, medical record requests, or letters. Fees vary depending on the time involved and the information requested. Please be aware that these fees are not covered by your insurance. We recommend scheduling an appointment to avoid incurring these charges.

INSURANCE INFORMATION

We are contracted with insurance companies. Your insurance may have a network of providers; if so, our participation in that network will be verified by our billing office prior to your visit. Some mental health services require prior authorization from your insurance company, such as Tricare Prime for out of network providers. It is your responsibility to confirm that the provider you are scheduled with is in your network prior to your appointment, and make yourself aware of your Mental Health insurance coverage. These include copay amounts, coinsurance amounts, and deductibles. Our staff, in order to bill your insurance(s), will have access to only that information necessary for preparing monthly statements and submitting claims to your carrier(s).

Medication Prior Authorizations

Some insurance companies require justification for medications you may be prescribed. This is called a prior authorization and they are handled in office by our staff and your provider. Prior authorizations require 24-72 hours for processing by CMPS and once sent to your insurance company, may take an additional 24-72 hours for them to approve or deny the requested medication. Prior authorization for a stimulant or benzodiazepine requires a drug screen. This will not be initiated until we have an up to date drug screen on file to submit with the request.

MEDICAL RECORDS

Virginia Laws Protecting Medical Record Privacy

Virginia Code § 32.1-127.1:03 declares that medical records are the "property of the provider maintaining them". The law recognizes "a patient's right of privacy in the content of a patient's medical record" and makes the practitioner responsible for ensuring that the patient's records are only released in accordance with law.
In Virginia, patients may access their own medical records, but may be denied mental health records if a provider believes doing so would be injurious or detrimental to that person's mental health.

How Can I Get A Copy of My Virginia Medical Records?

A request for copies of medical records must be in writing, dated and signed by the person making the request, and include a reasonable description of the records sought. If someone is making a request on your behalf, he or she must provide evidence of the authority to receive the records. (Virginia Code § 32.1-127.1:03).
Once your health care provider receives the request, he or she has 30 days to do one of the following:

1 Provide copies of the records;
2 Inform you if the information does not exist or cannot be found;
3 Inform you who now maintains the records; or
4 Deny the records for specific reasons set out under the law.

PRIVACY NOTICE

Our Pledge Regarding Private Health Information (PHI) This Notice of Privacy Practices is being provided to you as a requirement of the privacy regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how Coastal Medical and Psychiatric Services may use and disclose medical information about you to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control medical information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health condition. As required by law, we will only use or disclose your PHI in ways consistent with what is stated in your Privacy Notice. We reserve the right to change the terms of this Privacy Notice and to notify you of a new Privacy Notice effective for all PHI we maintain. In the event of a change to our Privacy Notice, we will provide you with the Privacy Notice upon request.

How We May Use and Disclose Privacy Information to You
The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures, we will explain what we mean and give examples if possible. Not all categories are able to be listed however all of the ways we use information and disclose information fall within one of these categories.

For Treatment: We may use and disclose your PHI for purposes necessary to provide your treatment. We do not need your permission, written or otherwise, to do this. We may disclose PHI about you to doctors, nurses, technicians or other healthcare personnel and providers who are involved in taking care of you. For example, lab results or procedures will be available in your record and available to health professionals who are providing treatment.

For Payment: We may use and disclose PHI about you so that treatment and services may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give you your health plan information on the date of services, the services provided, and the medical condition being treated to your insurance company.

For Health Care Operations: We may use and disclose PHI about you for healthcare operations. These uses and disclosures are necessary to run our office and make sure that all individuals receive quality care. For example, we may use PHI to review our treatment and services and to evaluate the care you are receiving through our providers and in our office.

Treatment Alternatives: We may use and disclose PHI to tell you about or recommend possible treatment options or alternative health related benefits or services that may be of interest to you.

Individuals Involved in your Care of Payment for your Care: We may release PHI about you to a friend or family member who is involved in your medical care with signed consent. We may also give information to someone who helps pay for your care. We may also tell your family or friends your condition and if you are in the hospital, we would relay that information to them.

Research: Under certain circumstances, we may use and disclose PHI about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another medication for the same condition. All research projects, however, are subject to an approval process and this process evaluates a proposal of how PHI will be used in the research. Before we disclose PHI for research, the project will have been approved through appropriate authorities. Documents with PHI information will not leave the office. We will ask you for permission if the research has access to your name, address, or other information that reveals who you are or who is involved in your care.

As Required By Law: We will disclose PHI about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose PHI about you when necessary to prevent a

serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to help someone prevent injury or prevent a threat from escalating.

Worker's Compensation: We may release PHI about you for worker's compensation or similar programs. These programs provide benefits for work –related injuries or illness.

Public Health Risk: We may disclose PHI about you for public health activities. These activities generally include the following: to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with a specific product; to notify people of recalls of products they may be using, to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition, and to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

Health Oversight Activities: We may disclose PHI to a health oversight agency for activities authorized by law. Activities include audits, investigations, inspections, and licensure. The activities necessary are for the government to monitor the health care system, government programs, and compliance with civil rights law.

Lawsuit and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request to allow you to attempt obtaining an order protecting the information requested.

Law Enforcement: We may release PHI if asked to do so by a law enforcement official : in response to a court order, subpoena, warrant, summons, or similar process; to identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime, or if under certain limited circumstances, we are unable to obtain the person's agreement related to a death; about criminal conduct in our office; and in emergency circumstances to report a crime, the location of the crime or victim, or the identity, description or location of the person who committed the crime.

National Security and Intelligence Activities: We may release PHI about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law. We may disclose PHI about you to authorized federal officials so they may provide protection to the President, or other authorized persons or foreign heads of state or those conducting special investigations.

Pursuant to Authorization:
We will require a signed authorization from before we disclose your PHI to a third party for reasons not listed above. We will retain a copy of any signed authorization you give us that is attached to a request to us for your PHI. We will also keep a record of when, to whom, and what we provided in response to the request for disclosure. If you have signed an authorization for us to use or disclose your PHI, and decide you want to revoke the authorization, you have the right to revoke it. You must revoke the specific authorization in writing and deliver it to the Privacy Officer at the address listed previously on this form and indicate the effective date of the revocation. Once we receive the request for revocation, or have knowledge you authorized the revocation, we will make note of it to assure that we do not make future disclosures pursuant to your original authorization.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact the Privacy Officer at the address listed below. All complaints must be submitted in writing to the Privacy Officer. You also have the right to complain to the Department of Health and Human Services, Office of Civil Rights. You will not be penalized for filing a complaint.
Contact Information
Attention: Privacy Officer
825 Diligence Dr. Ste 100 & 206
Newport News, VA 23606

CMPS
COASTAL MEDICAL & PSYCHIATRIC SERVICES INC.

PATIENT INFORMATION

First Name _____ M.I____ Last Name _____

Address_____

City/State/Zip_____ SSN.# _____

Marital Status: S M D W Sex: M F Date of Birth _____/_____/_____ Age _____

Primary Phone _____ Secondary Phone _____

Email _____

PARENT/GUARDIAN

(Required if patient is a minor and under the age of 18)

Name _____ Date of Birth _____/_____/_____

Relationship to Patient _____ SSN.# _____

Address (if different) _____

Home Phone _____ Work Phone _____ Cell Phone _____

INSURANCE INFORMATION: INSURED OR RESPONSIBLE PARTY (POLICY HOLDER)

Policy Holder Name _____ Relationship to Patient _____

Insurance Company _____ Member ID _____

Effective Date _____ SSN# _____ DOB _____/_____/_____

Please sign if you authorize CMPS to leave voice mails containing patient information on the phone number(s) listed above:

Signature of Patient/Guardian: _____ **Date:** _____

COASTAL MEDICAL & PSYCHIATRIC SERVICES INC.

RELEASE OF INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

SSN:_____ Contact Phone Number: _____

I authorize the individuals listed below the use and disclosure of my health information which may include but is not limited to scheduling appointments, handling prescriptions, and speaking with my provider on my behalf.
This Release of Information may be edited at any time per written addendum provided by my provider.

1. Name: _____ Medical / Billing / Emergency

Relationship: _____ Phone Number: _____

2. Name: _____ Medical / Billing / Emergency

Relationship: _____ Phone Number: _____

3. Name: _____ Medical / Billing / Emergency

Relationship: _____ Phone Number: _____

4. Name: _____ Medical / Billing / Emergency

Relationship: _____ Phone Number: _____

Please Indicate below the information you would like disclosed

_____ Care and condition
_____ Test Results
_____ Psychological/Mental Health/Psychiatric Information
_____ Pick Up Prescriptions/samples
_____ Pick Up Forms
_____ Make/Cancel Appointments

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is by my request to release my medical records to the entity or facility listed above. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that by signing this release form, if I have requested a copy of my medical records previously, that there may be a charge for an additional copy.

Signature of Patient/Guardian: _____ **Date:** _____

COASTAL MEDICAL & PSYCHIATRIC SERVICES INC.

PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth: _____/_____/_____

1. Yes No Is your general health good?
2. Yes No Have there been changes in your health in the last year?
3. Yes No Have you been hospitalized for a serious injury in the last year?
   If YES, why? _____
4. Yes No Are you being treated by a physician now?
5. Are you currently experiencing any of the following:

Yes	No	Chest Pain	Yes	No	Dizziness
Yes	No	Swollen Ankles	Yes	No	Ringing in Ears
Yes	No	Recent weight loss, fever, night sweats	Yes	No	Headaches
Yes	No	Persistent cough	Yes	No	Seizures
Yes	No	Bleeding problems, bruising easily	Yes	No	Fainting Spells
Yes	No	Sinus Problems	Yes	No	Blurred Vision
Yes	No	Difficulty Swallowing	Yes	No	Excessive Thirst
Yes	No	Diarrhea, constipation, blood in stool	Yes	No	Frequent Urination
Yes	No	Frequent vomiting or nausea	Yes	No	Dry Mouth
Yes	No	Difficulty Urinating, blood in Urine	Yes	No	Joint or Muscle Pain

6. Do you have a history of any of the following:

Yes	No	Heart Disease	Yes	No	AIDS
Yes	No	Heart attack, heart defects	Yes	No	Tumors or Cancer
Yes	No	Heart murmurs	Yes	No	Arthritis
Yes	No	Rheumatic fever	Yes	No	Eye Disease
Yes	No	Stroke, hardening of arteries	Yes	No	Skin Disease
Yes	No	High blood pressure	Yes	No	Anemia
Yes	No	Asthma	Yes	No	Herpes
Yes	No	Hepatitis or other liver disease	Yes	No	Kidney or Bladder Disease
Yes	No	Stomach problems or Ulcers	Yes	No	Thyroid Disease
Yes	No	Allergies to drugs, food, or medication	Yes	No	STD
Yes	No	Family history of diabetes, heart problems	Yes	No	Diabetes

7. Have you ever been treated for:

Yes	No	Psychiatric care	Yes	No	Hospitalization
Yes	No	Radiation Treatments	Yes	No	Blood Transfusion
Yes	No	Chemotherapy	Yes	No	Surgeries
Yes	No	Prosthetic Heart Valve	Yes	No	Pacemaker
Yes	No	Artificial Joints	Yes	No	Any Valves

If YES to any, Please Explain: _____

8. Do you have a past or present use of:

Yes	No	Recreational Drugs	Yes	No	Tobacco
Yes	No	Medication Drugs including over the counter	Yes	No	Alcohol

If YES to any, Please Explain: _____

9. Yes No Are you or could you be pregnant or nursing?
10. Yes No Are you using birth control
11. Yes No Do you or have you had any medical problems NOT listed on this form?

If so, Please Explain: _____

To the best of my knowledge, I have answered each question completely and accurately. I will inform my provider of any change in my health and/or medications.

Signature of Patient/Guardian: _____ **Date:** _____

FINANCIAL POLICY

Payments and copays for all services will be due at the time services are rendered. In order to serve you better we accept cash, Visa, MasterCard, and Discover. As a courtesy to you, it is the policy of CMPS to bill your insurance carrier, although you are ultimately responsible for the entire bill. As the responsible party, please understand:

PLEASE READ AND INITIAL THE FOLLOWING:

_____1. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, secondary insurance and "usual and customary" charges. As your medical provider, we will only supply factual information to facilitate claim processing.

_____2. Fees for services, which include unpaid balances, deductibles and copayments are due at the time of service. If these balances are not paid in a timely manner, we have the right to cancel your appointment until you have paid a majority of the remaining balance. Returned checks and unpaid balances may be subject to collection placement and collection fees. The office will mail at least one statement. If payment is not received by statement due date your account will be considered delinquent. Delinquent accounts will receive notice of delinquency followed by a final notice. Failure to make payment may result in further legal actions.

_____3. I accept responsibility for payment of all treatment that the payer (insurance) determines does not constitute covered services, court costs and any other costs of collection should such action become necessary. Collection costs may include an attorney fee of up to 33.1/3%, a returned check fee of $62.00, and interest on delinquent balance should such action become necessary.

_____4. **I UNDERSTAND THAT I WILL BE CHARGED FOR ANY APPOINTMENTS NOT KEPT UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE.** No Show fees are $65.00, and the Late Cancellation is $40.00 and my insurance will not cover that charge. The law does not allow CMPS to bill insurance companies for missed appointments; therefore, I, the patient, am fully responsible for these fees.

_____5. All charges are your responsibility whether your insurance company pays or does not pay. If any payment is made directly to you for services billed by CPMS, you recognize an obligation to promptly remit payment to CMPS.

_____6. You understand and agree that if you fail to make any of the payments for which you are responsible in a timely manner, after such a default and upon referral to our collection agency or attorney by CMPS, you will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

At CMPS, we understand that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call our billing department at 757-223-2939.

I UNDERSTAND THE ABOVE INFORMATION AND WILL BE RESPONSIBLE FOR THE PATIENT LISTED BELOW:

Printed Name of Patient: _____

Signature of Patient/Guardian: _____ **Date:** _____

Subpoena Contract

This contract is an agreement between the interested parties that no party shall attempt to subpoena my testimony or my records for a deposition or court hearing of any kind for any reason.

All parties acknowledge that the goal of psychiatric treatment is the improvement of psychological/mental distress and interpersonal conflict, and that the process of treatment depends on trust and openness during the sessions.

Therefore it is understood by all parties that if they request my services as a psychotherapist, play therapist, or prescriber, they are expected not to use the information given to me during the therapy process for their own legal purposes or against any of the other parties in a court or judicial setting of any kind.

_____ _____
Printed Name of Patient Relationship to client

_____ _____
Signature Date

If you have legal guardianship, power of attorney, or the patient is under the age of 18, please sign for yourself as their personal representative:

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

_____ _____
Printed name Relationship to client

_____ _____
Signature Date

Acknowledgment of Welcome Letter & Privacy Notice Packet

I hereby acknowledge that I have received a copy of the Privacy Practices of CMPS, Inc.

Patients Name: _____

Date: _____

Signature of Patient or Parent/Guardian: _____

If you are signing as the personal representative of the patient:

Personal Representatives Name: _____

(Office Use Only)

CMPS, attempted to obtain written acknowledgment of receipt of the Notice of Privacy Practices, but acknowledgment could not be obtained because:

[ ] Individual refused to sign

[ ] An emergency situation prevented us from obtaining acknowledgment

[ ] Other (Please specify below)

Employee Signature: _____

Date: _____

CMPS Policy on Benzodiazepines and other Controlled Substances

According to the 2012 National Survey on Drug Use and Health, almost twice as many Americans (6.8 million) currently abuse controlled pharmaceuticals than those using cocaine, heroin, hallucinogens, and inhalants combined. As prescribers, we are ethically and legally obligated to take precautions to ensure that controlled substances we prescribe are not being misused or diverted.

In addition to this obligation, our first obligation is to your health and well-being. Benzodiazepines (such as Ativan/lorazepam, Valium/diazepam, and Klonopin/clonazepam) are potentially lethal in overdose, especially when used in combination with alcohol or opioids. Side effects and risks of benzodiazepines include, but are not limited to: memory and thinking problems; dementia; worsening anxiety, PTSD, COPD or sleep apnea; physical dependence and withdrawal symptoms; overdose; arrest for driving while impaired; increased risk for falls, broken bones and concussion. These medications were developed for short-term use in extreme situations. The likelihood of experiencing adverse effects, and decreased efficacy of the medication, is more likely with regular or long-term use. While each patient will be evaluated on a case-by-case basis, if you are prescribed benzodiazepines at CMPS it will be your provider's goal to decrease and discontinue their use as much as possible over time.

With these concerns in mind, we have written the following agreement in the interest of promoting optimal drug therapy while minimizing risks to the patient and the health provider:

1. I, _____ agree not to increase the dose or frequency of my medication without first discussing it with my psychiatric provider. I understand that expected refill prescription refill dates will be used to promote optimal use of this medication.
2. If prescribed controlled substances, my provider will require baseline and random laboratory drug screening or pill counts as a matter of routine monitoring.
    a. Screening and pill counts may occur while I am in the office during appointments, or I may be potentially notified of the need for screening or pill counts in between appointments and given a 24-hour window to present myself at the CMPS office for monitoring.
    b. All results are final and any inconsistencies may result in discontinuation of controlled substances, and/or discharge from the practice.
3. I will attend all scheduled appointments, treatments, and consultations as requested by my provider. I understand that I should check with my provider or pharmacist before taking over the counter medications and/or herbal supplements.
4. I agree to be responsible for the secure storage of my medication at all times. I understand the importance of not informing others about my controlled substance therapy. I agree not to give or sell my prescribed medication to any other person.
5. I agree to attend and meaningfully participate in psychotherapy if my provider makes it a condition of being prescribed benzodiazepines.
6. I understand the following refill policy will apply, unless I have made previous arrangements with my provider:
    a. Early medication authorizations will not be granted, even if they have been lost, stolen, or destroyed.
    b. Medication authorizations will not be given on Fridays, weekends, or holidays.
    c. Medications will not be refilled by other physicians or providers.
7. I have been fully informed of the potential psychological and physiological dependence risks of controlled substances; I know that some persons may develop a tolerance, which is the need to increase the dose of the medication to achieve the desired effect. I know that I may become physically dependent on the medication. This will occur if I am on the medication for several weeks; when I stop the medication, I must do so slowly and under medical supervision, or I may have withdrawal symptoms.
8. I consent to open communication between my provider and any other health care professionals involved in my medication management, such as pharmacists, other providers, emergency departments, etc.
9. I understand that if I break this agreement, our healthcare provider - client relationship will be terminated.

Signature of Patient/Guardian: _____ Date: _____

Informed Consent for Telehealth/Telemedicine Services

I _____ hereby consent to engaging in telehealth/telemedicine services with Coastal Medical and Psychiatric Service, Inc, as part of my mental health resources, psychotherapy, and medication management. I understand that telehealth/telemedicine Includes the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that telehealth/telemedicine also involves the communication of my medical/mental information, both orally and visually, to health care practitioners located in Virginia.

I understand that I have the following rights with respect to telehealth/telemedicine:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. I understand that the laws that protect the confidentiality of my medical information also apply to telehealth/telemedicine. As such I understand that the information disclosed by me during my therapy/treatment is generally confidential. However, there are both mandatory and permissive expectations of confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards a victim; or threatening to harm myself.
3. I understand that there are risks and consequences for the telehealth/telemedicine, including but not limited to the possibility that, despite reasonable efforts on the part of the practice, the transmissions of my medical information could be disrupted by technical failures.
   In addition, I understand that telehealth/telemedicine-based services and care may not be as complete as face to face services. I also understand that if my provider believes I would be better served with a face to face visit, or the conditions where telehealth/telemedicine should be terminated, I (the patient) will return to in person care.
4. I understand that I will be responsible for any copayments, coinsurance, or deductibles that apply to my telehealth/telemedicine visit.
5. I understand that all existing laws regarding my access to medical information and copies of my medical records apply to this telehealth/telemedicine consultation.
6. I understand that the telehealth/telemedicine visit will be done through a two-way video link-up. The healthcare provider will be able to see my image on their screen and hear my voice. I will also be able to hear and see my healthcare provider.

Signature of Patient/Guardian: _____ **Date:** _____

AGREEMENT TO RECEIVE ELECTRONIC COMMUNICATION

1. Name: _____ ____ _____
   First Name MI Last Name

2. Date of Birth: _____ / _____ / _____
   MM DD YY

3. Initial Below:

   I **DO** Agree: I **DO NOT** Agree:

That the business may communicate with me electronically at the email address and/or phone number listed below.
I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the business any updates to my email address and / or mobile phone number.

4. I would like to receive appointment reminders: ☐

5. Most Preferred Method of Communication:

   ☐ Text Message ☐ Email ☐ Both

6. Please Provide Contact Information:

   Email: _____ Phone: _____

I can withdraw my consent to electronic communications by signing a revocation form at:
Coastal Medical and Psychiatric Services
825 Diligence Drive Suite 206 & 100, Newport News, VA 23606
Phone: 757-310-6900
Fax: 757-240-5936

Signature of Patient/Guardian: _____ **Date:** _____

*Please remember that text and email reminders are a courtesy and not a guarantee. Patients or their parent/guardian are fully responsible for keeping track of and remembering scheduled appointments.

Phone (757)310-6900 Secure Fax (757)240-5936

Authorization to Release Information to PRIMARY CARE PHYSICIAN

*Patient Name: _____ *Date of Birth: _____/_____/_____

_____ - **Please initial if you do not have a PCP or do not want to disclose information to them**

I hereby authorize Coastal Medical and Psychiatric Services to obtain and disclose information regarding my care from:

*Name of Agency/Provider: _____

*Phone/Fax: _____

Dear _____,

Your patient was seen by me on _____. His/her plan of care includes:

_____

_____

_____

_____

_____

If you have any questions, please do not hesitate to contact our office.

Sincerely,

*Print Patient Name and/or Legal Guardian: _____ Date: _____

*Signature:_____

This release may remain valid until revoked in writing or until termination of care with either provider.

COASTAL MEDICAL & PSYCHIATRIC SERVICES INC.

Card on File: Authorization Form

Information to be completed by Cardholder:
The undersigned agrees and authorizes Coastal Medical and Psychiatric Services to save the credit card indicated below on file. The use of this form is optional and for your convenience.

Medical Practice: Coastal Medical and Psychiatric Services

Patient's Name: _____ DOB: _____

Name as it Appears on the Credit Card: _____

Type of Credit Card: ___ MasterCard ___ Visa ___ Discover ___ Amex

Credit Card Number: _____

Expiration Date: _____/_____ CCC Code: _____

I, _____, authorize Coastal Medical and Psychiatric Services to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

I, _____, **authorize/do not authorize (circle one)** Coastal Medical and Psychiatric Services to process the above credit card for my copay/coinsurance on the date of my appointment. I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date Cardholder's Name

Patient will receive a receipt via email when the payment has been processed.