Credit Card Pre-Authorization For Use by Susan Martin, PMHNP

I authorize Susan Martin, PMHNP, to keep my signature on file and to charge my credit card for payment of my session in the amount established by my provider ___________ for the following purposes:

amount

1. For a no-show or missed session without a 24-hour cancellation notice.
2. For past due sessions.

- I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session. I will be notified, verbally, by my provider that the missed session or the past due session payment will be applied to my credit card.

- I also understand that if I want to use my credit card for my session(s) that I will make a payment at the end of the session I will be attending using the physical credit card.

- I agree that this form is valid for the length of therapy and authorization for the use of this card will be canceled at the termination of therapy.

Client's Name: ____

Card Holder's Name: ____

Card Holder's Address: ____

City: ______________________________ State: _________ Zip: ____________

Phone: ____________________________ Email: ________________________________

▢ Visa ▢ Mastercard ▢ American Express ▢ Other: ______________________________

Account #: __________________________________ CVV #: __________ Exp. Date: _________

3 digits on back of card

Signature: ____

Susan Martin, PMH-NP

Controlled Substance Agreement

These guidelines address medications including stimulants, benzodiazepines, and sedatives. As with all medications, make sure that you understand what medication is prescribed, why you take it (what it is meant to treat) , and most important, how to take the medication.

Do not take more medication than prescribed without discussing your needs with either the covering provider or me. Medication quantities will not be charged without prior discussion. Refilling your prescription prior to the expected date will not be authorized.

If there are any issues related to a change in prescribed use that has not been discussed with the covering provider or me, you may be asked to schedule an earlier appointment. This is for safe medication use, a review of the risks and benefits of using the medication, and to consider alternatives.

Diverting (selling or sharing) medication has become a significant public health risk not only in Maine but also in the United States. The medications that are prescribed for you are for your use only. If you lose either your written prescription or your filled prescription (Bottle) you will be required to contact your local police and provide documentation of this report. You will not be able to obtain a replacement supply.

You may be asked to provide a random urine drug screen. If you are unable to comply with this request within the time frame required (often in the same day) , the use of controlled substances will no longer be a part of your treatment plan under my care.

Inability to adhere to these guidelines may result in dismissal from my practice.

I understand and agree to the above guidelines.

____ ____________________

Patient Date

____

Susan Martin, PMH-NP

Susan Martin PMH-NP

Authorization to Disclose Confidential Information

_________________________________ Client/Consumer Name (Please Print)

_________________________________ Date of Birth

_________________________________ Guardian Name (If applicable. Please Print)

_________________________________ Relationship to Client/Consumer

I give my permission to Susan Martin, PMHNP-BC to: ▢ **Release**
▢ **Obtain confidential information as specified below**
▢ **To** ▢ **From**

Agency/Organization Name: ____________________________ Contact Person: ______________________
Mailing Address: ______________________________ Phone: ______________ Fax: ______________
City/Town: ___________________________ State: ____________ Zip Code: ____________

Unless otherwise specified information may be released or obtained verbally, via fax transmission, via mailed copies, or by email.

INFORMATION PERTAINING TO (check all that apply):

▢ Psychiatric/Medication Management Services
▢ Psychological Evaluations/Services
▢ Mental Health Treatment Services

INFORMATION IS FOR THE FOLLOWING PURPOSE(s) (check all that apply):

▢ Ongoing treatment/continuing care
▢ Coordination with past/current treatment providers

I understand the following:

1. I may inspect or receive a copy of protected health information to be disclosed.
   ▢ I DO ▢ I DO NOT wish to review records prior to their disclosure.
2. My signature on this form authorizes the disclosure of protected health information.
3. This authorization is in effect until one year from today, ____________________ *(enter today's date).*

Signatures
By signing below, I confirm that I have had this form explained, have had an opportunity to ask questions about it, authorize the disclosure of confidential information as described in this document, and have been offered a copy of this form.

Client signature: ____ Date: _____/_____/_____

To the recipient of Confidential Information:
If information released to you by this authorization contains substance abuse evaluation or treatment information, please be informed that federal law (42 CFR, Part 2) prohibits further disclosure of this information without the written consent of the identified persons except as otherwise permitted by law.

Susan E. Martin, PMHNP
15 Pleasant Hill Road, Suite 204 * Scarborough, ME 04074

Financial & Insurance Office Policy

Self Pay/No Insurance

The fee for an Initial Psychiatric Evaluation is $350.00.

The fee for a Medication Management follow-up appointment is dependent upon time necessary:

45 minutes - $225 30 minutes - $150 15 minutes - $75

Payment in full is expected at the time of service.

Rates above are not broken down by CPT code as insurance is not being billed.

Cash, personal checks, HSA, credit or debit cards accepted.
A receipt for payment will be provided upon request.

Insurance Policy

Susan Martin, PMH-NP is in network with Anthem BCBS, Aetna MaineHealth & Community Health Options (CHO). We will submit claims on your behalf. We will verify your insurance coverage and advise you of your policy benefits for outpatient psychiatric care. You will be responsible for your copay or deductible/co-insurance at the time of service.

Your are responsible of notifying our office immediately of any insurance changes. Should your policy terminate or have a lapse in coverage, you are responsible for all outstanding charges.

If ***Susan Martin, PMH-NP*** is out of network with your insurance company, we will submit a claim on your behalf as a courtesy. Should you have out of network benefits, your insurance company will process your claim toward those benefits. If payment is made, they will reimburse you directly. You are responsible for payment in full at the time of service.

Most common billable services are:

Initial Evaluation	CPT Code	99205	$350
(60-74 mins which includes review of records, phone calls, coordination of care and face-to-face with patient)			
	CPT Code	99204	$275
(45-59 mins which includes review of records, phone calls, coordination of care and face-to-face with patient)			
E&M Medication Management CPT Codes:		99213	$100
		99214	$150
Psychotherapy Add-On Code to E&M:		90833	$ 75
		90836	$100

Cancellation policy

If for any reason you can't keep your appointment, kindly provide 24 hours' notice or you'll be charged $100.00 for that session. This charge will be billed directly to you, not to your medical insurance company. The only exceptions to this no-show policy are cases of extreme emergencies, or unpredictable weather.

Returned checks: A service charge of $25.00 will be added for returned checks.

____________________________ ________________
Patient Date

Susan E. Martin, PMH-NP
15 Pleasant Hill Road, Suite 204
Scarborough, ME 04074

Consent for Treatment with Psychotropic Medication

I, ______________________________, hereby authorize **Susan Martin, PMH-NP** and those who cover in her absence to treat me with: _________________________.

Susan Martin, PMH-NP has informed me of the benefits, risks, and alternatives to this medication, as well as its possible side effects, including: _______________________________
____.

In the case of antipsychotic medications, I understand there is a risk that I may experience tardive dyskinesia, which causes involuntary tic-like movements in the face, tongue, neck, arms and/or legs, and which may persist even after the medication is discontinued. In the event that I become pregnant, I understand that psychotropic medications are not indicated in pregnancy and may result in adverse effects to the infant.

I understand that I should immediately contact the office if I experience any significant side effects. Although Susan Martin, PMH-NP believes that this medication will assist in the treatment of my illness, I understand that there is no guarantee as to the results that may be expected from such treatment.

I understand that I may discontinue my prescribed medication at any time. However, I recognize that if I stop the medication, I may experience serious side effects and that I should, therefore, consult Susan Martin, PMH-NP before making such a decision. I further understand that if I have any additional questions regarding the prescribed medication, I may ask at any time.

____ ______________________
Patient Date

____ ______________________
Susan Martin, PMH-NP Date

SUSAN E. MARTIN PMH-NP

15 Pleasant Hill Road, Suite 204 * Scarborough, ME 04074

Personal Information

Last Name ______________________ First & Initial______________________

Address ______________________ City, State ______________ Zip ________

Home Phone # ______________________ Cell Phone # ______________________

Date of Birth ______________________ Email: ______________________

Please contact me via: ____ cell phone ____ email **Permission to leave message: _____ Yes ____ No**

SS #: ______________________ Employer:______________________

Person to Notify in Case of an Emergency ______________________

Relationship ______________________ Phone # ______________________

Primary Insurance ***: Include Photo of Insurance Card, Front & Back***

Insurance Company Name ______________________ Policy Holder ______________________

Member ID Number ______________________ Group Number ______________________

Secondary Insurance: If Applicable, include Photo of Card, Front & Back

Insurance Company Name ______________________ Policy Holder ______________________

Member ID Number ______________________ Group Number ______________________

Are you currently seeing a Therapist? *If so, please provide information:*

Name ______________________ *For How Long?:* ______________________

Address ______________________ ***City, State*** ______________________ ***Zip*** __________

List of Current Medications

Medications & Dosage: ______________________

____

I ***certify that I am the person responsible for payment on this account. I understand that it is my responsibility to pay for all services rendered, even if I provided insurance information.***

The information provided above is true and accurate to the best of my knowledge:

Signature: ______________________ Date:______________________

Printed Name: ______________________

Relationship to Patient: ______________________

- - - - - - - - - - - - - - - - - - FOR OFFICE USE ONLY - - - - - - - - - - - - - - - - - - -

Notes:

Dx Code 1:__________________

Dx Code 2:__________________

Dx Code 3:__________________