Easter Seals New York Mental Health Clinic and Diagnostic & Treatment Center

Intake– Patient Information

Patient Name: _____

Date of Birth: _____ **Social Security #:** _____

Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: (___) _____ [ ] patients private [ ] parent/guardian [ ] agency

Gender: [ ] Male [ ] Female **Email address:** _____

Preferred Method of Contact:

[ ] Home Phone [ ] Cell Phone [ ] Other Phone [ ] Mail

Race: [ ] American Indian/Alaska Native [ ] Asian [ ] Black/African American
[ ] White/Caucasian [ ] Hawaiian/Pacific Islander [ ] Other [ ] Decline

Ethnicity: [ ] Hispanic/Latino [ ] Not Hispanic/Latino [ ] Decline

Primary Language, if other than English: _____

Emergency Contact: _____ _____ _____
Name Phone Relationship

Patient's current residential setting: [ ] Alone [ ] Family [ ] Friend/others [ ] Family care

[ ] Residential agency housing Type: _____

Agency Name: _____ Phone: _____

Primary Care Physician: _____
Address: _____
Phone: _____ Fax: _____

Consent for Treatment: I hereby give my consent for Easter Seals Diagnostic and Treatment Center, to provide diagnostic and clinical services to me/my child/ward, the above named individual, so long as I choose to receive services from the DTC.
Print Name: _____

Signature: _____ Date: _____

(If the patient is over 18 years old and does not have a legal guardian the patient may be the signor)

Relationship to patient (Check appropriate choice): [ ] Self [ ] Parent [ ] Guardian

Name of person preparing this Form: _____ Date: _____

Phone #: _____ Fax #: _____

easterseals New York

Easter Seals New York Mental Health Clinic and Diagnostic & Treatment Center

Patient Name: _____ Date of Birth: _____

Receipt of the HIPAA Privacy Regulations and Bill of Rights

I have received a copy of the Easter Seals NY Notice of Information Practices for Release of Health Information in compliance with the Privacy Regulations of HIPAA and am aware of its contents. I have also received a copy of the Patients' Bill of Rights in accordance with NY State Department of Health.

I understand that if I have questions, at any time, regarding the Easter Seals New York DTC compliance with HIPAA or regarding the Patients' Bill of Rights, I may phone the DTC to speak with an employee of EasterSeals or request an appointment to speak with an employee of Easter Seals to discuss my questions.

Signature: _____ **Date:** _____

Relationship to patient (Check appropriate choice): [ ]Self [ ]Parent [ ]Guardian

Legal Guardian (if applicable)

Has guardianship been legally established? [ ]yes [ ]no [ ]pending [ ]not applicable

Guardian Name: _____ Relationship to Patient: _____

Address: _____

Phone: _____

Foster Care (if applicable)

Foster Care Agency: _____ Date placed in Foster Care: _____

Case Worker Name: _____ Phone #: _____

Email: _____

Foster Parent Name: _____ Phone: _____

Email address: _____

Financial Guarantor: _____ [ ] self [ ] parent [ ] other

Name & relationship of other: _____

Address: _____

Phone: _____

The financial guarantor is not responsible for paying for services him/herself (except a parent on behalf of a minor) out of personal funds. The financial guarantor is legally responsible for the management of the patient's personal funds and is responsible for payment of the patient's financial obligations including medical bills.

Patient Name: _____ Date of Birth: _____

Financial Policy

Easter Seals New York, Inc. ("ESNY") behavioral health clinic is committed to providing you with quality care. We want to be sure that you completely understand the fees for our services and what you may need to pay if your insurance plan does not cover the cost of services or if you have no insurance. We will always be available to answer any questions you may have about our services, our fees, your insurance payments or insurance statements, payments from other parties and insurance coverage. This Financial Policy Agreement is intended to help you understand the costs of our services and your obligations for payment. Please read and sign this agreement.

Cost of Service & Appointments

Every service provided by this program has a cost. If you have insurance, all or part of these costs may be covered by your insurance. Some insurance policies have a Co-Pay, Co-Insurance, or Patient Responsibility that you will need to pay at the time of your visit. The payments you owe are determined by your insurance plan. We will discuss your costs with you before you begin treatment. If you do not have insurance, you will be responsible for payment, based on our fee schedule at the time of your visit.

Please keep all scheduled appointments or let us know within twenty-four hours if you cannot keep your appointment. ESNY is committed to you and to providing the services you need, however if you do not keep your appointments, do not notify us before the appointment or cancel multiple times we may no longer be able to provide services to you.

Private Pay

Clients who fall into any one of these three categories are considered to be private pay:

1. ***No Insurance Coverage***
2. ***Insurance Coverage that ESNY does not Participate in***
3. ***Indemnity Coverage (You can choose any provider)***

If you cannot afford our private pay fees, please let us know and we will work with you to adjust our fees based on your income and family size.

Managed Care (when ESNY participates)

If you have managed care insurance you need to know what your insurance plan covers. Contact your plan to talk to them about your coverage and what your copayment or deductible may be. You may also want to ask if ESNY services need authorization before the services begin. We are here to help so speak to someone in our Billing Office if you have questions about your insurance plan.

Deductible: Some managed care plans have a deductible. If we receive notice from your plan that a part of your deductible has been applied to ESNY services you will need to pay the deductible amount at your next visit.

Copayments: Some managed care plans require that you pay a co-payment for each service provided. If your plan requires a co-payment, this payment will be collected at each visit upon check in. Co-payments are non-negotiable as they are a part of the contract between yourself and your insurance carrier.

Number of visits/maximum benefits: Some managed care plans have a limit to the number of visits you may have and type of services you may receive from us. If you want to continue to receive services after your plan stops paying ask to speak with the ESNY Billing Office so that we can discuss the costs with you.

Non-covered services: Some service types may not be covered by your insurance. If at all possible we will tell you before the appointment in order for you to decide if you want to proceed as private pay.

Medicaid (Non Managed Care)

If you have regular (Non-Managed Care) Medicaid, you must show your active Medicaid Card at <u>every</u> visit. We will determine at each visit if you are covered. If you are not covered at the time of service and have not been to the Medicaid office to fix this, you may have to pay for your visit. If you are new to Medicaid, you will be private pay until your Medicaid coverage is active. Once your coverage is active, ESNY will send claims for services that have already been provided. If we are paid for services already provided and you have paid the fee, the fee will be refunded to you.

Spend down: If you have a Medicaid spend down you will be need to give us a copy of the letter stating the amount of monthly spend down. If you have a Medicaid spend down, you can:

1. Pay at the Medicaid office each month before you have services or;
2. Pay at each visit until you have paid the monthly spend down amount

Patient Name: _____ Date of Birth: _____

Medicare Part B
Medicare has a yearly deductible and co-insurance. You are required by law to pay ESNY for any deductible or co-insurance that Medicare tells us is owed by you (if you do not have other insurance that will pay these costs).

VERY IMPORTANT: It *is very important* that you notify us if there is any change in your insurance coverage.

- If your insurance becomes inactive, you may be responsible for payment for services provided.
- If you receive a letter from Medicaid or Computer Science Corporation about your **service limits** please bring the letter to your next visit.
- If you receive a letter telling you that you need to recertify your Medicaid benefits (once a year) **please contact the Medicaid office immediately or you may lose your benefits** and be responsible for paying for all your medical/dental services including those you receive at ESNY.

Insurance Releases and Authorizations

I, the undersigned, authorize ESNY, its providers, or its agent to submit claim(s) to my insurance carrier for payment. In addition I authorize release/give any information and copies of my medical records (including information about mental illness and/or AIDS/ARC/HIV/substance abuse as outlined in the HIPAA Privacy Notice supplied at registration) needed by my insurance company to review medical claims for services provided at ESNY. I authorize payment of my insurance benefits to be made directly to ESNY from any insurance or other third-party payer.
I agree to pay ESNY for any services provided which are not covered by my insurance carrier or other third party payer.
I have read, understand and agree with all information in the Financial Policy Agreement.

Medicare Beneficiaries
I certify that the information given by me in applying for payment under the Medicare Program (Title XVIII of the Social Security Act) is correct. I agree that any holder of medical or other information about me may release to the Medicare Program (Social Security Administration, Health Care Financing Administration, or intermediaries or carriers) any protected health information (including information about mental illness and/or AIDS/ARC/HIV) needed to review claims for my medical services. I request that the Medicare Program send payment to ESNY, the Part B Provider directly instead of to me. I assign to the Part B Provider all benefits payable for professional services rendered by ESNY, the Part B Provider.

_____

Print Name of Patient, Guardian, Guarantor Signature Date

_____

Print Name of Witness Signature Date

IF an ESNY REPRESENTATIVE SIGNS AUTHORIZATIONS AND AGREEMENTS ON BEHALF OF PATIENT, COMPLETE THE FOLLOWING:
(As Required by IOM 100-4, chapter 1, section 50.1.6 c.)

Patient Name: _____ Provider/Facility Name: Easter Seals New York, Inc.

____ Patient is unable to sign Authorizations and Agreements because of a physical or mental condition.

____ The following individuals are unavailable to sign Authorizations and Agreements on behalf of Patient:
Legal Guardian - Relative - Friend - Governmental Agency Providing Assistance

Representative Payee (designee of SSA or other government agency to receive incompetent beneficiary's monthly cash benefits)

Representative of Facility

Signature: _____ Date: _____

Name: _____ Title: _____