Suellen E. Stevens M.D.
2000 Warrington Way, Suite 210
Louisville, KY 40222
(502) 657-4551
Fax- (502) 919-7515

Welcome New Patients

We look forward to meeting you as a new patient in our office. As a new patient it is necessary to read and complete the new patient registration form and patient history form prior to your scheduled appointment. If the paperwork is not completed and received at least 5 days prior to your appointment your appointment may have to be cancelled or rescheduled. After your paperwork is completed please fax the paperwork to (502) 919-7515 or drop it off at our office.

The cost of the initial visit is $310.00 and will last approximately one hour. Dr. Stevens does not participate with any health insurance carriers. You will be responsible for payment in full at the time of your visit. We accept cash, check, Discover, Mastercard, Visa and American Express. Patients that arrive without payment on their scheduled appointment day will be asked to reschedule. If you have insurance, our office will provide you with a completed claim form for you to submit to your insurance carrier to assist you in obtaining possible reimbursement.

Please bring a photo ID and a list of your current medications and any other current medical information you may have available.

If you have any questions or concerns, please call our office at (502) 657-4551. Thank you for your interest, we look forward to meeting you.

Sincerely,

Ginny Costello
Office Manager

PLEASE COMPLETE IN BLACK INK ONLY
PATIENT INFORMATION

PATIENT'S NAME			SOCIAL SECURITY #	BIRTHDATE	AGE
PATIENT'S ADDRESS					
CITY	COUNTY		STATE	ZIP	
HOME TELEPHONE #	WORK TELEPHONE #		CELL TELEPHONE #	EMAIL ADDRESS	
SEX ❑ MALE ❑ FEMALE	MARITAL STATUS SINGLE MARRIED SEPARATED DIVORCED WIDOWED PARTNER'S NAME:				
PRIMARY CARE PHYSICIAN					
PRIMARY CARE PHYSICIAN'S ADDRESS & TELEPHONE #					
EMPLOYER'S NAME AND ADDRESS					
EMPLOYMENT STATUS FULL-TIME PART-TIME RETIRED DISABLED NOT EMPLOYED					
STUDENT STATUS: If 19 yrs or older FULL-TIME PART-TIME NOT A STUDENT					

Patient Name: ______________________________ Date Completed: ___________________

PATIENT INFORMATION/AUTHORIZATION/CONSENT

I, _________________________, give permission to Suellen E. Stevens M.D., PLLC to render treatment.

I authorize exchange of information between Suellen E. Stevens M.D., PLLC and my treating physician regarding my care.

My treatment and care will be confidential except under the following circumstances:

Threat of imminent harm to myself or others

Allegations of recent or ongoing abuse to another individual

A court-ordered subpoena of records

The documentation maintained about my case is the property of Suellen E. Stevens M.D., PLLC. Only with my written authorization can this information be released to another physician, service provider or agency. I understand that receiving psychiatric or psychological treatment and having a psychiatric diagnosis may adversely affect my ability to obtain life, disability or long-term care insurance. I agree to release Suellen E. Stevens M.D., PLLC from any liability if I have difficulty obtaining insurance due to the contents of my medical records.

I authorize the release of any information requested by my insurance carrier or pharmacy regarding the dispensing of prescribed medications including, but not limited to, diagnoses and health history. I authorize the release of any clinical or demographic information required by a laboratory to perform tests requested by Suellen E. Stevens M.D., PLLC.

I understand that if I have not been seen face-to-face by Suellen E. Stevens M.D., PLLC in over a year, I am no longer considered to be an active patient. I agree to release any form of medical liability for events occurring one year after the face-to-face contact.

I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is my responsibility to pay all fees in full. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

In order to control the cost of billings, I understand that charges for office visits are to be paid at the beginning of each visit.

I understand that if I have a balance on my account that is over 90 days old it will be subject to being referred to a Collection Agency. Any personal information needed to collect the debt will be provided to the Collection Agency. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney’s fees and costs of collection.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I understand that I will be billed in full for missed appointments or appointments not canceled by giving a 24-hour notice.

I understand that I may be billed for prescription phone calls and phone consultations.

I understand that interest at the rate of 18% per annum will be assessed to delinquent accounts.

___________________________________ ___________________________

Signature (Patient or parent if under 18 years of age) Date

___________________________________ ___________________________

Witness Date

Suellen E. Stevens M.D. , PLLC

POLICY AND PROCEDURES

The primary mission of the Suellen E, Stevens, M.D. is to provide the highest quality mental health and substance abuse services for individuals 12 years of age and older residing in central and eastern Kentucky. The range of services provided includes outpatient psychotherapy and psychopharmacology management. We endeavor to meet the needs of our patients and referral sources in a timely, efficient, courteous and professional manner.

In return for this conscientious care, we ask our patients to cooperate with the following guidelines:

INITIAL VISIT

An evaluation of the patient will be performed to determine psychiatric diagnoses. A treatment plan will then be designed with the patient which may include hospitalization, medications, routine lab tests, individual or family therapy.

OFFICE HOURS

Tuesday – Thursday 9:00am – 4:00pm
Monday & Friday New patient evaluations and emergency appointments

APPOINTMENTS

Patient visits are by appointment only. Our office will make every effort to adhere to our schedule so that you are seen on time. However, emergencies do occur and you will be advised if the doctor is running behind. In turn, we ask you to be punctual. If you are late by more than 10 minutes of the scheduled appointment time you may be rescheduled.

If you cannot keep an appointment, please call our office as soon as possible. Failure to keep an appointment or to cancel 24 hours in advance will result in a charge of $130. (Please note that insurance companies do not pay for missed appointment charges. Such charges are the responsibility of the patient.) We have a voicemail system that takes messages 24 hours a day. Patients who frequently miss scheduled appointments may be terminated from the practice for noncompliance.

EMERGENCIES

1. If you have a medical emergency, call 911 immediately.
2. If you have a psychiatric emergency, such as suicidality, please call the office (657-4551) 24 hours a day/7 days a week.

FEES AND BILLINGS

Please refer to the Financial Policy enclosed in this packet.

MEDICATIONS

Refills for controlled substances and/or Schedule II medications will not be given early for any reason including theft or lost medication.

Intentional misuse of prescribed medication will result in dismissal from our practice.

HOSPITALIZATION

Dr. Stevens will see patients in the office only. If hospitalization is required, the patient will be referred to the hospital that is covered by his or her insurance company. The admission and on-going treatment while in the hospital will be at the discretion of the on-call physician at the hospital, but Dr. Stevens will be available for telephone consultation with the physician, should that physician request it. Upon discharge, the patient is encouraged to schedule a return appointment with Dr. Stevens as soon as possible.

Suellen E. Stevens M.D. , PLLC

MEDICAL RECORDS (PROTECTED HEALTH INFORMATION)

We request that all patients advise us before treatment if they are involved in a lawsuit. Our records concerning your treatment are strictly confidential. Such information is available to referring and treating physicians so that your care can be complete. We will ask you to sign a release of information to these physicians at your first visit. However, your information may be disclosed to your insurance carrier as part of the insurance contract for payment and may be disclosed to your pharmacy or laboratory as needed. A full Notice of Privacy Practices is to be posted in the office and you may request a copy.

FORMS AND TELEPHONE CALLS

Patients will be billed for time spent completing forms not relating to billing of charges for services received in this office.

Patients may also be billed for telephone calls involving the doctors. Insurance companies do not pay for phone calls.

PATIENT RESPONSIBILITY

To assure that you receive the quality care you deserve, please assist us by doing the following:

1. Notify our business office of any changes in your residence, phone number or insurance.
2. Keep your appointments as scheduled or notify the office at least 24 hours in advance of any change.
3. Be prepared to pay for your appointments on the day you are seen or arrange a payment plan prior to your visit.
4. Monitor your medications so that you do not run out between appointments.
5. Notify us in advance of any need to release your records for legal or other purposes. It could take up to 10 business days to compile the needed records/information.
6. Be truthful with the doctors and staff.
7. Follow the agreed treatment plan.

TERMINATION OF CARE

Either the patient or the doctor can terminate the doctor/patient relationship for any reason he or she deems appropriate.

Reasons for our termination of your care could include:

1. Providing misleading or untruthful information.
2. Not following the agreed treatment plan.
3. Using medication outside the prescribed directions resulting in requests for early refills.
4. Excessive unwarranted phone calls during the workday and/or after hours.
5. Repeated failure to keep appointments.
6. Failure to tell us that you are in a lawsuit or facing criminal charges.
7. Failure to comply with the Financial Policy.
8. Aggressive or inappropriate behavior towards doctors/staff.

Patient Signature: ______________________________

Date: ______________________________

Suellen E. Stevens M.D., PLC

FINANCIAL POLICY

It is the goal of Suellen E. Stevens M.D., PLLC to provide the highest quality of psychiatric care. It is also our desire to assist you in the financial arrangements related to this care. Therefore, it is important for you to fully understand that our financial, credit and collection policies are a necessary part of assuring the financial resources needed to maintain this healthcare facility for our patients and community. Please read this policy statement carefully and feel free to ask any questions regarding any area. Please sign this statement indicating that you have read and understand each point. A copy of this signed statement will be given to you and a copy will be maintained in your chart.

Payment must be made at the time of your visit. If you have insurance coverage, you will be responsible for payment in full at the time of your visit but our office will provide you with a completed claim form for you to submit to your insurance carrier to assist you in obtaining your reimbursement. If unusual circumstances make it impossible for you to meet our credit terms, we invite you to discuss these with our office manager before your visit.

If you have a balance on your account that is over 90 days old it will be subject to being referred to a Collection Agency. Any personal information needed to collect the debt will be provided to the Collection Agency. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney’s fees and costs of collection.

Please feel free to call our office should you have any questions.

I have read, understand and agree to comply with the above financial policy.

Patient Signature: ______________________________

Date: ______________________________

Suellen E. Stevens M.D., PLLC
Notice of Privacy Practices
Effective June 4, 2010

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this Notice please contact our office manager. This Notice of Privacy Practices describes how we may use and disclose your protected health information 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 your protected health information. "Protected health information" (hereafter referred to as PHI) is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent:
You will be asked by your physician to sign a treatment authorization form, which indicates that you consent to use and disclosure of your PHI for treatment, payment and health care operations. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of circumstances where use and disclosure of your PHI are permitted (this list is descriptive but not exhaustive):

- The coordination or management of your health care with a third party, such as a home health agency, the physician who referred you to our office or to whom our doctors have referred you.
- Diagnoses and billing information provided to laboratories for requested testing.
- Diagnoses, billing information and medication prescribed made available to pharmacies.
- Determination of eligibility and insurance benefit coverage, medical necessity review and utilization reviews activities.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may leave a message for you on your voice mail system or answering machine concerning an aspect of your treatment or reminding you of an appointment.
- We will share your PHI with third party "business associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization:
Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object: We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI. If you are not present or able to agree or object to the use or disclosure of the PHI, then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is relevant to your health care will be disclosed.

Others Involved in Your Healthcare: Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's responsibility for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

Emergencies: If your physician or another physician covering for the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he/she may still use or disclose your PHI to treat you.

Communication Barriers: We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using professional judgment, that you intend to consent to use or disclosure under the circumstances.

1. **Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object**:

We may use or disclose your PHI in the following situations without your consent or authorization. These situations include:

Required By Law: We may use or disclose your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.

Public Health: We may disclose your PHI for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.

Communicable Diseases: We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your PHI to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your PHI if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime, (4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of the practice, and (6) medical emergency (not on the Practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose PHI to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death

Research: We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: We may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500 et. seq.

2. Your Rights Regarding Your Protected Health Information:

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. *Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI*. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our office manager if you have questions about access to your medical record.

You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. *Your physician is not required to agree to a restriction that you may request*. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our office manager.

You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our office manager to determine if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. We will not retaliate against you for filing a complaint.

You may contact our office manager at (502) 657-4551 for further information about the complaint process. This notice was published and becomes effective on June 4, 2010.

I acknowledge that I have read and understand the Notice of Privacy Practices posted for the office of Suellen E. Stevens M.D., PLLC.

_______________________________ _______________________

Patient Signature Date

Suellen E. Stevens M.D., PLLC
2000 Warrington Way, Suite 210
Louisville, KY 40222
(502) 657-4551
(502) 919-7515 fax

Suellen E. Stevens, M.D.
Board Certified in General Adult Psychiatry

Patient Name (*please print*): ___________________

In an effort to further safeguard your protected health information (PHI), this office would like to extend you the opportunity to list family members or friends you may choose to interact with our doctors or the office staff for various reasons on your behalf. For example, there may be people you might authorize to call the office to confirm or change your appointments for you, pick up prescriptions or samples from the office, pick up copies of your medical records, speak to the doctor about your condition, etc. You may revoke this authorization in writing at any time. If you do not choose to list anyone, please write "None" on the first space and sign and date the form.

Please list:

Full Name and Address of Contact	Relationship to Patient	Telephone Number	May we contact this person in case of an emergency? (please indicate at least one emergency contact)

___________________________________ ________________________
Patient's Signature Date

____
Witness