Advanced Practice
— MENTAL HEALTH AND WELLNESS —

Advanced Practice Mental Health and Wellness

Phone: 843-945-1452 Fax: 843-945-1489 Email:info@apmhofsc.com

## Locations:

**Myrtle Beach**
630 Chestnut Road
Myrtle Beach, SC 29572

**Loris**
3997 Meeting Street
Loris, SC 29569

**Florence**
2141 B Hoffmeyer Rd
Florence, SC 29501

**Georgetown**
1837 N Fraser Street
Georgetown, SC 29440

## PRACTICE POLICIES & INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

I understand that I am eligible to receive a range of services from my provider. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me. The goal of the assessment process is to determine the best course of treatment for me. Clinicians may choose to use AI for documentation purposes.

**CONTROLLED MEDICATION POLICY:** You **MUST BE SEEN** in the office every three months or sooner depending on provider discretion for your evaluation and management of your medication. Failure to keep these appointments could prevent your medication refill. If you miss your appointment **YOUR MEDICATION WILL NOT BE REFILLED UNTIL YOU ARE SEEN. ANY and ALL medication requests will be filled in 24-72 hours.**

**TELEHEALTH APPOINTMENTS:** If you are scheduled for a telehealth appointment, the office will give you a call two days prior to collect your copay**. Payments for telehealth appointments are due by 10am the day of scheduled appointment. If payment is not collected prior, this will result in a no show.**

**Billing Practices and Financial Agreement:** Your insurance company will require that your provider include on any billing statement of services a Procedural Code(s) called a CPT code and a Primary Diagnostic Code, or ICD Code. By submitting your insurance information and requesting that we bill your insurance company on your behalf, you are giving this practice the following "signature on file" permissions: permission to release private information necessary to process the insurance claim on your behalf. Payment in full is expected at the time of service. This includes your portion of the fee not covered by your policy, including any co-payments or co-insurance, and if applicable, meeting your required annual deductible. You will also be responsible for any portion of the balance due that is denied by the insurance company, regardless of the circumstances.

In order to attend your appointment, all of copay must be paid in full. If there is a balance, at least 20% of the balance must be paid.

•Acceptable forms of payment are cash, check, or debit/credit card and flexible spending cards. If your check is deposited and returned for insufficient funds, you will be charged a $35.00 Insufficient Funds Fee.
•We reserve the right to temporarily suspend scheduling further appointments if an outstanding balance is not paid and/or payment arrangements are not made in advance.

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**CANCELLATION AND LATE ARRIVAL**: Since your appointments involve the reservation of time specifically for you, a minimum of 24-hour notice is required for rescheduling or cancelling an appointment. **If 24-hour notice is not provided, you may be charged a $25.00 late cancellation appointment fee.** If you are going to be MORE than 15 minutes late to your scheduled session, please notify us as soon as possible. If your provider is unable to accommodate the late arrival, you will need to reschedule, and this may result in a $50.00 no-show/late cancellation fee. Please note, insurance companies will not reimburse for missed sessions or sessions that are cancelled late, and you will be responsible for the $50.00 no-show fee or $25.00 late cancellation appointment fee to be paid prior to being seen at your next scheduled appointment time. **Confirming** appointments through our email and text reminders that are sent out in advance is **required** for telehealth and in office appointments.

**TREATMENT TERMINATION:** If you are a no-show patient with three consecutive missed appointments, we will not schedule any further appointments and you will be **discharged** from the practice. If, after the intake, your nurse practitioner or therapist identifies your treatment needs are out of their scope of practice, we will refer you to an appropriate provider.

**Contact of Staff Policy**

Kindly refrain from reaching out to our clinicians via Facebook. We value your privacy and want to maintain the highest standards of confidentiality.
Preferred mode of communication: For any inquiries or appointment scheduling, please call our dedicated line at 843-945-1452. Our friendly staff will be happy to assist you during regular business hours.
**After-Hours Communication:** If a clinician has personally provided you with an after-hours contact number, feel free to use that number for necessary messages. Please respect the nature of their availability and contact them only as instructed. If you are experiencing medication complications or a mental health crisis, please go to your nearest emergency or call 988 Crisis hotline.

**URINE DRUG SCREEN POLICY:**

Initial medication management appointments require a urine drug screen. This will be billed to insurance or self-pay rate of $20.00.

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## Consent for Treatment & Policies Acknowledgement

**Name** _____ **Date of Birth** _____

I have read The Informed Consent for Assessment and Treatment and Office Policies, and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I hereby consent for my provider to release information to the billing agent/funding source and for the billing agent/funding source to release information to your provider. I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co-pays at time of service. I also understand the cancellation policy and that I will be responsible for the late cancellation and/or no-show fee if I do not provide 24-hour notice. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes the clinician or his/her billing specialist to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co- pay, coinsurance or deductible amount at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for assessment or psychotherapy to the providing clinician, for services rendered.

My signature indicates that I have read, understood, and been offered a copy of the document, Informed Consent for Assessment and Treatment and Office Policy, and any other document(s) mentioned above.

_____ _____

Patient Name Patient Signature

_____ _____

If signed by other than Patient, indicate relationship DATE