



## **Intake Assessment Form**

### **Child and Adolescents**

Thank you for choosing Oasis Mental Wellness as the place to provide high quality, compassionate care for your psychiatric concerns.

This practice treats patients age 5+ and takes insurance. If you have an HMO or other policy that requires referral from a Primary Care Provider (PCP), we will need a referral as required by your insurance.

Please provide the following to establish care as a patient at this practice:

- Completed New Patient Packet (below)
- Copy of Insurance Card (required)
- Copy of Photo ID (optional)
- Copy of Pharmacy Benefits insurance card (in case provider needs to complete a Prior Authorization for a medication prescribed to you)

Copies of your insurance card and photo ID can be sent to [info@oasis-mw.com](mailto:info@oasis-mw.com)

If you do not have insurance, please state that when you send a copy of your photo ID.

Please allow up to 4 business days after you have completed all the steps above for us to call and book you for an appointment.

\_\_\_\_\_ Sign here (parent/guardian/patient) to acknowledge that you have read and understood the above information



DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

LEGAL NAME

(patient): \_\_\_\_\_

(last)

(middle)

(first)

GENDER: M F Other

Preferred Gender Pronouns: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

### ETHNIC BACKGROUND

( ) White/Caucasian ( ) Black/African-American ( ) Hispanic/Latino

( ) Asian ( ) Native Hawaiian/Pacific Islander ( ) American Indian/Native Alaskan : ( ) Other

MAILING

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

May I send mail to the above address?: Y N

PHYSICAL ADDRESS (if different): \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_

EMAIL: \_\_\_\_\_ May I email you at this address: Y N

TELEPHONE NUMBERS:

HOME: \_\_\_\_\_ May we leave a detailed message?: Y N

WORK: \_\_\_\_\_ May we leave a detailed message?: Y N



CELL: \_\_\_\_\_ May we leave a detailed message?: Y N

APPOINTMENT REMINDER PREFERENCE: ( ) TEXT ( ) EMAIL

Parent/Legal Guardian Name 1: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Parent/Legal Guardian Name 2: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Phone #: \_\_\_\_\_

Employer/Occupation: \_\_\_\_\_

Financial Responsibility (if different than above): \_\_\_\_\_

#### PREFERRED PHARMACY

(NAME): \_\_\_\_\_

(LOCATION): \_\_\_\_\_

(PHONE): \_\_\_\_\_



## INSURANCE COVERAGE

PATIENT NAME (as listed on insurance  
card): \_\_\_\_\_

INSURANCE  
COMPANY: \_\_\_\_\_

CUSTOMER SERVICE  
PHONE#: \_\_\_\_\_

MENTAL HEALTH PHONE # (if  
different): \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

(as listed on insurance card): \_\_\_\_\_

RELATIONSHIP TO  
PATIENT: \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER  
ADDRESS: \_\_\_\_\_

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POLICY HOLDER DOB: \_\_\_\_\_

POLICY HOLDER SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_

GROUP #: \_\_\_\_\_



Additional insurance (secondary plan):

INSURANCE COVERAGE

PATIENT NAME (as listed on insurance  
card): \_\_\_\_\_

INSURANCE  
COMPANY: \_\_\_\_\_

CUSTOMER SERVICE  
PHONE#: \_\_\_\_\_

MENTAL HEALTH PHONE # (if  
different): \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

(as listed on insurance card): \_\_\_\_\_

RELATIONSHIP TO  
PATIENT: \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

ADDRESS: \_\_\_\_\_

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POLICY HOLDER DOB: \_\_\_\_\_

POLICY HOLDER SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_

GROUP #: \_\_\_\_\_



Additional insurance (tertiary plan):

INSURANCE COVERAGE

PATIENT NAME (as listed on insurance  
card): \_\_\_\_\_

INSURANCE  
COMPANY: \_\_\_\_\_

CUSTOMER SERVICE  
PHONE#: \_\_\_\_\_

MENTAL HEALTH PHONE # (if  
different): \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

(as listed on insurance card): \_\_\_\_\_

RELATIONSHIP TO  
PATIENT: \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

ADDRESS: \_\_\_\_\_

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POLICY HOLDER DOB: \_\_\_\_\_

POLICY HOLDER SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

SUBSCRIBER ID#: \_\_\_\_\_

GROUP #: \_\_\_\_\_



INSURANCE COVERAGE (Pharmacy Benefits Card)

PATIENT NAME (as listed on insurance card): \_\_\_\_\_

PHARMACY BENEFITS

MANAGER: \_\_\_\_\_

Rx BIN #: \_\_\_\_\_ Rx Group: \_\_\_\_\_

ID: \_\_\_\_\_

CUSTOMER SERVICE PHONE#: \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER (as listed on insurance card): \_\_\_\_\_

RELATIONSHIP TO PATIENT: \_\_\_\_\_

POLICY HOLDER/SUBSCRIBER

ADDRESS: \_\_\_\_\_

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POLICY HOLDER DOB: \_\_\_\_\_

POLICY HOLDER SS#: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Referred by:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_ Pediatrician/Family Medicine Provider \_\_\_\_ MD/DO/PA/NP Specialist

\_\_\_\_ Psychologist \_\_\_\_ Social Worker \_\_\_\_ Therapist

\_\_\_\_ Other: \_\_\_\_\_



Family members residing in the house:

| NAME | RELATIONSHIP | GENDER | AGE | DOB |
|------|--------------|--------|-----|-----|
|      |              |        |     |     |
|      |              |        |     |     |
|      |              |        |     |     |
|      |              |        |     |     |

EMERGENCY

CONTACT: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_ PHONE: \_\_\_\_\_



## Child/Adolescent Developmental History (AGES 5-17)

To be completed by child's parent/guardian or patient if patient is age of consent

Child's Full Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary Care Provider or Practice: \_\_\_\_\_

Date of child's last physical exam: \_\_\_\_\_

### DEVELOPMENTAL HISTORY

At what age did your child:

Wean from breast \_\_\_\_\_ Wean from bottle \_\_\_\_\_ Sat unassisted: \_\_\_\_\_

Use two-word sentences \_\_\_\_\_ Walk \_\_\_\_\_ Toilet train \_\_\_\_\_

Were there any delays in development (speech, motor)? If so, please describe:

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Please describe what your child was like between ages 0-4 in regards to these below:

Ability to soothe him/herself when upset:

Showing initiative and curiosity:

Dependent on external rewards to achieve behaviors desired by parents:

Avoiding harm:

Activity level:



## MEDICAL HISTORY

Were there any medical problems during pregnancy: Yes No

If so, please describe: \_\_\_\_\_

Was your child born naturally, or by C-section?: \_\_\_\_\_ Child's birth weight: \_\_\_\_\_

If delivered naturally, were any assistive devices (forceps, vacuum extraction) used? Yes No

Was your child exposed to medications, toxins, alcohol, cigarettes, marijuana or illicit substances before birth? Yes No

If so, please list: \_\_\_\_\_

Was your child born on time?: Yes No If not, at how many weeks gestation? \_\_\_\_\_

Has your child had any surgeries: Yes No

If so, please list what types and at what age: \_\_\_\_\_

Has your child ever had a seizure, head trauma or loss of consciousness? Yes No

List: \_\_\_\_\_

Has your child ever had an EEG or head imaging (CT or MRI): Yes No

List: \_\_\_\_\_

Has your child ever been hospitalized for a medical condition? Yes No

List: \_\_\_\_\_

Has your child ever been in the emergency room: Yes No

List: \_\_\_\_\_

Has your child been evaluated for any type of heart condition: Yes No

Describe: \_\_\_\_\_



Please check any symptoms below that your child is currently having:

|                                   |                             |                                               |
|-----------------------------------|-----------------------------|-----------------------------------------------|
| ___ Weight changes                | ___ Stomach discomfort      | ___ Headaches                                 |
| ___ Dizziness                     | ___ Muscle or joint pain    | ___ Easy bruising or bleeding                 |
| ___ Chest pain/heart palpitations | ___ Numbness or weakness    | ___ Fever                                     |
| ___ Trouble breathing             | ___ Hair loss               | ___ Skin problems                             |
| ___ Nausea or vomiting            | ___ Constipation            | ___ Fainting                                  |
| ___ Changes in vision/hearing     | ___ Problems with urination | ___ Menstrual problems/suspicion of pregnancy |

## PREVIOUS TREATMENT

Is this your first mental health consultation?: Yes No

Previous psychiatric hospitalizations (hospital name, dates of hospitalization, treatment received during hospitalization):

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Previous or current psychotherapy: Name of therapist/agency, dates of treatment, type of therapy if you know (CBT, DBT, psychoanalysis):

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## CURRENT MEDICATIONS

| Medication | Dose | Start Date | Side Effects |
|------------|------|------------|--------------|
|            |      |            |              |
|            |      |            |              |
|            |      |            |              |
|            |      |            |              |
|            |      |            |              |

Known allergies to medications: \_\_\_\_\_

Any other allergies: \_\_\_\_\_

## EDUCATIONAL HISTORY

Current school and grade level: \_\_\_\_\_

Grades on most report cards: \_\_\_\_\_

Has your child ever had an IEP (Individualized Education

Plan) or 504 plan?: Yes No

If so, starting in which grade? \_\_\_\_\_ In which category? \_\_\_\_\_

Please list any special services your child receives, either in school or privately  
(tutoring/resource, speech/language, advanced/gifted classes, occupational therapy): \_\_\_\_\_

\_\_\_\_\_

Has your child ever been expelled or suspended from school? Yes No If yes, when and why:

\_\_\_\_\_

Are you concerned about your child's academic performance? If so, please describe your concerns:

\_\_\_\_\_



## **FAMILY HISTORY (describe relationship)**

### **Medical**

Genetic conditions:

Thyroid disorder:

Diabetes:

Epilepsy:

Neurological disorders (MLS, Parkinson's, Alzheimer's):

Heart disease:

- Anyone in the family ever experience sudden cardiac death prior to age 40? Anyone suffer a major cardiac event prior to age 50?

Migraines:

Stroke:

Tics:

Liver disease:

Kidney disease:

Cancer:

### **Psychiatric**

Autism:

Learning disability:

Intellectual impairment:

ADD/ADHD:

Depression:

Anxiety (including panic):



PTSD:

OCD:

Eating disorder:

Bipolar disorder:

Psychosis:

Suicide (attempted and completed):

History of psychiatric hospitalization?

Substance abuse:

Parents' relationship status: \_\_\_\_\_

Any other regular caregivers (after school program, nanny, relatives)?: \_\_\_\_\_

\_\_\_\_\_

Child's extra-curricular activities: \_\_\_\_\_

Main reason for today's visit: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Other stressful issues your child may be dealing with: \_\_\_\_\_

\_\_\_\_\_



## **Consent for Psychiatric Treatment**

**TO THE PATIENT/LEGAL GUARDIAN(s):** The age to consent for medical treatment in the state of North Carolina is 18. This means that consent to treat patients under 18 resides with the legal guardian of the patient. However, North Carolina does allow patients under 18 to consent for treatment in the case of emotional disturbance or substance abuse. Because many mental health conditions can fall under the interpretation of “emotional disturbance” this means that minors can legally consent for care in certain situations while not involving their parents. However, this practice does partner with families and ideally wants to include parents in the care of a minor.

The patient along with legal guardian have the right to be informed of the patient’s condition and the recommended treatment plan. At this point in care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain permission to perform evaluations necessary to identify the appropriate treatment(s) to treat your condition.

By signing below the legal guardian(s) are indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommendation. This consent will remain fully effective until either you as the patient/legal guardian decide to discontinue treatment or the provider terminates care.

The patient along with the legal guardian has the right to discuss the treatment plan with your provider about purpose, potential risks and benefits of various aspects of your care. If you have any concerns regarding your treatment recommended by your provider, we encourage you to ask questions.

Although our responsibility to your child may require our involvement in conflicts between parents and guardians, we need your agreement that our involvement will be strictly limited to that, which will benefit your child. This means that you each agree as a condition of us treating your child that:

- You realize limits of confidentiality. That although we maintain full confidentiality of patient records with our providers and office staff, we cannot enforce confidentiality among family members, parents, siblings, and/or spouses. We do ask, however, that each party respect the confidentiality of the family member;



- Our role is limited to providing treatment and you shall not attempt to gain advantage in any legal proceeding relating to the care and custody of your child;
- You shall not request or require us, through subpoena, summons or other means (except as otherwise ordered by a court of competent jurisdiction) to provide testimony in favor of one parent/guardian against the other in any legal proceeding relating to the care and custody of your child;
- You understand that in the event that a provider is called into a legal or forensic relationship, or if any therapeutic material should be subpoenaed, at that point the therapeutic relationship will be considered terminated, and the provider will no longer provide psychiatric medication management/mental health services, but will fulfill legal obligations on a factual or forensic basis. In addition, you should be aware, if you should become involved in a legal matter and the provider is subpoenaed to court, even by another party, you will be charged a fee of \$250.00 per hour for any time spent in court (even when not testifying) as well as for time spent traveling, preparing;
- If there is a court appointed evaluator, and if appropriate authorization forms are signed, or a court order authorizing disclosure of treatment records is sent to us, we will disclose the requested treatment and general information about the minor but we will not make any recommendations concerning the child's custody or custody arrangements, unless otherwise ordered by a court.

Please select the most appropriate category below:

\_\_\_\_\_ Both Legal Parents/Guardians Consent to Treatment

- Both legal parents/guardians agree to psychiatric medication management/mental health treatment and providing of mental health services for their child and will indicate their consent below
- If the biologically or legally adopted parents are currently separated or going through a divorce process, both parents are still required to sign a Consent form for the child to be treated

\_\_\_\_\_ Divorce, Custody or Legal Issues

- There is an official certified divorce decree or a legal custody order that indicates that only one parent is legally permitted to determine and decide on psychiatric medication management/mental health treatment of the child without the consent of the other parent



(In this case, please provide us with a certified copy of this legal document in its entirety).

\_\_\_\_ Missing or Deceased Parent

- The parent presenting child for treatment has no access to the other parent due to the following reasons (death, in prison, missing, has left and made no contact, etc....) and therefore will acknowledge that they are the sole primary caretaker of the child for psychiatric medication management/mental health treatment and will bear all responsibility for such consent.

\_\_\_\_ Legal Guardians not present – Patient is age of consent and seeking care on his own for emotional disturbance and/or substance abuse issues or emancipated minor

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

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(Signature of Patient or Guardian) (if Guardian, include DOB)

Date

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(Signature of Patient or Guardian) (if Guardian, include DOB)

Date



## Financial Policy

Thank you for choosing Oasis Mental Wellness for your psychiatric treatment. We are committed to providing the highest quality of care. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your first appointment.

Full payment is due at the time of service. We accept cash, check, Visa, Mastercard or American Express. Our practice will file claims with your insurance as long as you are in-network. All patients with an insurance copay are expected to pay their copay in full at check in before seeing their provider. Our contracts with the insurer require that we collect this amount. The patient's agreement with the insurance company also requires payment of this fee by the patient at the time of service. After receiving payment from your insurance, if any remaining balance is due (e.g. deductible, coinsurance, past due balances), you will be issued a statement. You are expected to pay your bill within 60 business days of receipt of the statement. We are happy to work out a payment plan if you are having financial difficulty. A collections process may be started at the discretion of the business owner if patient statements are not paid within 60-90 business days. If your insurance is not accepted at this practice, self-pay rates apply. We are happy to provide a superbill for you to file to your insurance yourself in these instances.

Patients unable to meet their financial obligations at the time of registration (the initial evaluation) should either be rescheduled for another appointment or referred to the emergency room if they believe their condition warrants immediate care.

Parents/guardians are responsible for the costs associated with the treatment of minor children. The parent accompanying the minor child shall be responsible for any copay regardless of custodial rights.

**Medicare Patients:** As a participating provider of Medicare Part B (physician services) and Medicare Part C, Oasis Mental Wellness will bill you only for your Medicare coinsurance, deductible, and any services rendered but not covered by Medicare. All other services will be billed directly to Medicare.

Note: You will be informed of services not covered by Medicare Part B before they are rendered. Your signature on the appropriate Medicare waiver form known as the



“advance beneficiary notice” represents your authorization for the provider to perform these services and your acceptance of the financial responsibility for them. If you have Medicare Part A only, then the services you receive from our practice will not be covered by Medicare.

**HMO/Managed care insurance patients:** Many HMO/Managed care plans require that you obtain a referral in order to receive care from a specialist. It is your responsibility to obtain this referral if required. Unauthorized services will be the financial responsibility of the patient. Please have your referral forms and membership card available for scheduling/check in. You will be required to pay the copay for authorized services at the time of service.

Please know that some Managed Care Organizations require patients to complete laboratory work at a specific laboratory. If labwork is considered a part of the treatment plan, you as the patient are responsible for verifying if your insurance requires you to use a specific laboratory.

Unless cancelled at least 24 hours (1 business day) in advance, it is our policy to charge the practice fee for a missed appointment. These fees are listed on the website. Appointment reminders are a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment. It is up to the discretion of the practice to allow grace for no-show/cancellations in less than 24 hours.

There will be a \$50 fee for returned checks.

In compliance with the No Surprises Act, we want to inform you about potential additional charges associated with psychiatric medication management visits. These visits may include add-on therapy codes, which are separate from the base evaluation and management service. Add-on therapy codes reflect additional services provided during your visit, such as brief supportive psychotherapy, brief interventions or coordination of care beyond the standard evaluation.

Please let us know if you have any questions or concerns.

I have read the policy and agree to the terms, including an allowance for **assignment of benefits** which allows the provider I see at Oasis Mental Wellness to submit claims to my health insurer.

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(Signature of Patient or Guardian) (if Guardian, include DOB)

Date



## **Financial Policy Continued**

### **Credit Card on File Policy**

Oasis Mental Wellness, PLLC is committed to reducing waste and inefficiency and making the billing process as simple and easy as possible. We therefore require that you provide a credit card on file with our office. Payments are run through a HIPAA-compliant, secure practice management software Simple Practice. Your payment information is stored on Simple Practice's secure servers for future transactions. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system.

Payment is expected at the time of service through whatever payment method is desired – cash, check, Visa, Mastercard or Credit Card. If you cannot pay your amount at the time of the visit, it is up to the provider's discretion to allow the appointment to continue. For patients using their insurance plan, payment at the time of service includes your co-pay. For patients not utilizing insurance and paying as self-pay, payment for the full self-pay rate as advertised is expected at the time of service. It is imperative for this clinic to stay in business to collect payment promptly to be able to continue to operate.

During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.

Credits on your account will be returned to the credit card on file.

To avoid any issues of discrimination or favoritism, all patients will be required to have a credit card on file.

### **FAQs:**

#### **How does CCOF work? I am nervous about giving up my sensitive financial information.**

Your card information is securely protected by the credit-card processing component of our HIPAA-compliant practice management system. This system stores the card information for future transactions using the same sort of technology that credit card company's use. We cannot access the entire card number – we can only see the last 4 digits. There is no way to export the card information out of our system. We can only use it to process a payment in our practice management system, which creates an indelible record (one that cannot be deleted).



### **How the credit card on file system works to drive down administrative costs**

Staff will spend less time entering credit card information for each transaction. Once your CCOF is in our system, check-in and check-out time is much shorter for you as well. However, if you want to use a different card than the one on file for payment of your appointment, let the provider know.

### **How the CCOF process benefits patients**

First and foremost, it is far more convenient for you – you don't have to call the office or buy a stamp or worry about getting around to pay the bill. It takes the hassle out of the process, especially for patients who have HSA cards to pay for their medical care. If you want to use a different card, please let the office know promptly.

### **What if there is a problem with my bill and I don't notice it until after the payment processes?**

If you find a problem, call us and we will investigate it. If we owe you money, we will refund it promptly to the same card.

By signing below I agree to maintain a credit card on file:

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(Signature of Patient or Guardian) (if Guardian, include DOB)

Date

By signing below I am stating I do not agree to maintain a credit card on file but do agree to maintain a zero dollar balance for the patient account:

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(Signature of Patient or Guardian) (if Guardian, include DOB)

Date



### Notice of Privacy Practices

Our notice of privacy practices may be found on our website at [www.oasis-mw.com](http://www.oasis-mw.com)

You may also obtain a copy of this notice from staff. By signing below, you acknowledge receipt of this notice. You may refuse to sign this acknowledgement. Please understand that should you refuse to sign, Oasis Mental Wellness, PLLC will not be able to file your insurance and you would be fully responsible for charges.

I, \_\_\_\_\_, have read or received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Printed Name and relationship to patient if not the patient

\_\_\_\_\_  
Date



## Consent for Telepsychiatry Sessions

Please read the Telepsychiatry Consent and sign below. If you have questions, please let your provider know.

1. I understand that I am about to engage in a video psychiatry session with my provider.
2. I understand that a video session will not be the same as an in person session due to the fact that I will not be in the same room as my provider. I also understand that in order to have the best results for the session, I should be in a quiet room with limited interruption during the session.
3. I understand the potential risks of this technology include but are not limited to: interruptions, unauthorized access resulting in breach of privacy, technical difficulties, information transmitted may not be sufficient (for e.g. poor resolution of video), delays in medical evaluation or treatment due to deficiencies or failures of the equipment, and a lack of access to all of the information available in a face to face visit may result in errors in medical judgment. I understand that I or my provider may discontinue the video psychiatry session if it is felt that the video conferencing connections are not adequate for the session.
4. My provider agrees to inform me or obtain my consent if another person is present during the consultation for any reason. I agree to inform my provider if another person is present during the session. I understand that to record the session the patient needs to be aware and to consent to the recording.
5. I understand that there are alternatives to video psychiatry sessions and I may choose to come to the office for my appointment.
6. I understand that I can direct questions about this session at any time to my provider.
7. I understand that this consent will last for the duration with my provider and for future video psychiatry sessions. I can withdraw my consent for video psychiatry sessions at any time.
8. I understand that the same confidentiality protections, limits to confidentiality, and rules around my records apply to my video psychiatry session as they would to an in person session.
9. I agree to work with my provider to identify a safety plan including identifying one or two emergency contacts in the event of a crisis situation during our session.



10. I understand that my provider may choose to terminate video sessions if they deem it inappropriate for me to continue treatment via video sessions.

By signing this form I certify:

- I have read or have had this form read and/or had this form explained to me
- I fully understand its contents including risks and benefits
- I have been given the opportunity to ask questions and that any questions I have had been answered
- I agree to participate in video psychiatry sessions with a provider at Oasis Mental Wellness, PLLC

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Patient Name/Signature

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Patient Date of Birth

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Date

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If patient is a minor – name of responsible party, relationship to patient, and signature



## **PATIENT PORTAL MESSAGING AGREEMENT**

### **Oasis Mental Wellness**

#### **Purpose of the Patient Portal**

**The patient portal is offered as a convenience to facilitate limited, non-urgent communication between patients and their provider. It is not a substitute for a clinical evaluation or real-time interaction.**

#### **Appropriate Use**

**By signing this form, you understand that patient portal messaging is intended only for:**

- **Brief, non-urgent questions**
- **Appointment scheduling or administrative matters**
- **Medication refill requests (when appropriate)**
- **General updates that do not require clinical decision-making**

#### **Limitations & Clinical Appropriateness**

**You acknowledge and agree that:**

- **Patient portal messaging is not appropriate for complex, sensitive, or urgent medical or mental health concerns, including treatment decisions, diagnostic clarification, or significant symptom changes.**
- **Messaging through the portal is asynchronous, meaning it does not occur in real time and does not allow for immediate clarification or follow-up questions.**
- **Information shared via messaging may be incomplete or lack necessary clinical detail, which can impact the provider's ability to make safe and informed decisions.**
- **As a result, care delivered through portal messaging is inherently more limited in scope and quality than care provided during in-person or telehealth appointments.**



### **Provider Discretion & Standard of Care**

**You understand that:**

- **Your provider will use their professional judgment and clinical expertise to determine whether your concern can be appropriately addressed عبر messaging.**
- **If your provider determines that your concern requires further evaluation, you may be asked to schedule an appointment.**
- **This recommendation is made to ensure care is provided in accordance with accepted standards of medical and mental health practice, including appropriate assessment, documentation, and risk evaluation.**
- **Failure to participate in a recommended appointment may limit the provider's ability to safely continue treatment or respond to your concerns.**

### **No Guarantee of Response or Clinical Action**

**You acknowledge that:**

- **Messages are reviewed during regular business hours only and are not continuously monitored.**
  - **Response times may vary but are typically within 1–3 business days.**
- **The provider cannot guarantee immediate review, response, or clinical action based on any message submitted through the portal.**
- **Use of the portal does not establish or modify the provider's duty to provide urgent or emergency care.**

### **Emergencies and Urgent Situations**

**You agree that you will not use the patient portal for urgent or emergency concerns.**

**If you are experiencing a mental health emergency or need immediate assistance:**

- **Call 911, or**
- **Go to your nearest emergency room, or**



- **Contact the 988 Suicide & Crisis Lifeline by calling or texting 988**

### **Risk Acknowledgment**

**By using the patient portal, you acknowledge and accept the inherent risks associated with electronic communication, including but not limited to:**

- **Delays in response or communication**
- **Misinterpretation of information due to lack of real-time interaction**
  - **Incomplete clinical assessment**
  - **Technical or system-related issues**

**You agree that these limitations may affect the quality and timeliness of care provided through the portal.**

### **Confidentiality & Security**

**While reasonable safeguards are in place to protect your information, electronic communication carries some level of risk. By using the portal, you consent to this form of communication and understand its limitations.**

### **Consent and Agreement**

**By signing below, you acknowledge that you have read, understand, and agree to the terms of this Patient Portal Messaging Policy. You agree to use the portal only as outlined and understand that your provider may require an appointment for concerns that cannot be safely addressed through messaging.**

**SIGNATURE (Patient or Guardian):** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **PATIENT AGREEMENT**

### **New Patient Appointments**

- Arriving 20 minutes or more late will result in the office rescheduling my appointment and incurring a \$75 fee
- If I need to cancel or reschedule my new patient appointment I will call 24 hours in advance (not including weekends and holidays); otherwise I will incur a \$75 fee
- Should I no-show to my new patient appointment the office reserves the right to not reschedule my appointment.

### **Follow Up Appointments**

- Arriving 15 minutes or more late will result in the office rescheduling my appointment and incurring a \$50 fee
- If I need to cancel or reschedule my new patient appointment I will call 24 hours in advance (not including weekends and holidays); otherwise I will incur a \$50 fee

\*Please note that Saturday and Sunday are not valid cancellation days. If you have a Monday appointment or appointment after a holiday, you will need to contact us the business day prior to your scheduled appointment.

### **Privacy concerns for MINORS and PARENTS:**

- While privacy in therapy is very important, particularly with teenagers, parental involvement is also essential to successful treatment and this requires that some private information be shared with parents. It is the policy of this practice not to provide treatment to a child under age 12 unless he/she agrees that we can share whatever information is necessary with his/her parents. For children 13 and over, we request an agreement between the patient and his/her parents allowing us to share general information about the progress of the child's treatment and his/her attendance at sessions. We will also provide parents with a summary of child's treatment when it is complete. Any other communication will require the child's authorization, unless we feel that the child is in danger or is a danger to someone else, in which case, we will notify the parents of our concern. Before giving parents any information, we will discuss the matter with the child, if possible, and do our best to handle any objections he/she may have.



### **Medication Management**

- Refills will not be given if I have not been seen in the past 3-6 months and I acknowledge there are restrictions around Class II controlled substances like stimulants that treat ADHD which per law requires appointments every 90 days for new scripts to be sent in
- I will request refills through my pharmacy 5 days before running out of medication.
- I will request refills for controlled substances from my provider 3-5 business days prior to running out of medication. I will send a request through the portal or leave a message on my provider's voicemail.
- I will notify my provider immediately if I am prescribed a controlled substance by another provider.

### **Other aspects of care**

- For all messages sent to my provider, I will allow 3 business days for a response whether it is for a medication refill or other question. I will communicate if my request is urgent but will do my best to communicate with as much advance notice as possible.
- I understand that this practice has limited availability Monday-Friday for accepting calls or scheduling appointments and that scheduled appointments are according to provider availability; I understand that my provider will throughout the week even while not open for appointments check messages and return calls regarding things related to my care – but that I should not expect my provider to get back to me on holidays and that there should be a minimum of 3 business days allowed for responses
- I understand that for the completion of forms that I need to give as much advance notice to my provider. I will do my best to submit forms 7-10 business days prior to when they are needed. I also understand that my provider may need to have a face to face appointment with me to go over the form.

### **Contacting Oasis Mental Wellness, PLLC**

- Our providers have limited availability to answer phone calls throughout the week due to work schedules. There are no on call services provided by this clinic after business hours Monday-Friday. Though our providers make their best effort to promptly return phone calls/messages, we cannot interrupt patient care to get back to you. Please leave a detailed message with the best time to call back as well as the preferred contact method. If you are unable to reach your provider at Oasis Mental Wellness, PLLC and feel that you cannot wait for your provider to return your call, you may contact: your family medicine



provider/pediatrician, call the National Mental Health Crisis Number at 988, call the Hopeline at (919) 231-4525, call Holly Hill Hospital Respond Line at (919) 250-7000, or go to your nearest crisis center/emergency room and ask for the psychiatrist/psychologist on call. In the event of a life-threatening emergency call 911.

### **Termination**

- Patients are under no obligation to continue services should they decide to terminate at any time. However, we strongly urge you to notify your provider in person so it can be discussed openly.

### **Complaints**

- Your provider will take reasonable precautions to minimize risks, insure your safety, and provide you with a positive experience. If at any time you believe that your provider has not been diligent in performing services, or you believe that your privacy rights have been violated, please bring this to your provider's attention so we can address the matter. If there are concerns that we are not able to resolve to your satisfaction, the North Carolina Medical Board can be contacted to review and evaluate any concerns you may have or to file a complaint. You can file a privacy complaint to the Secretary of the U.S. Department of Health and Human Services. Your provider will not retaliate against you for filing a complaint.

I have read and understood the patient agreement.

Name of responsible party, relationship to patient, and signature:

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Date: \_\_\_\_/\_\_\_\_/\_\_\_\_



## Authorization to Release/Obtain Medical Information

Patient Name \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

I hereby authorize \_\_\_\_\_ at Oasis Mental Wellness, PLLC  
to

\_\_\_ **Release** protected health information to (either in verbal or written form):

\_\_\_ **Obtain** protected health information from (either in verbal or written form):

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

State: \_\_\_\_\_ Zipcode: \_\_\_\_\_

### Information to be released or accessed in verbal or written form:

Dates of service: \_\_\_\_\_

\_\_\_ All medical records including diagnostic evaluation, progress notes, phone calls, labs  
consults, imaging reports, etc...excluding psychotherapy notes.

\_\_\_ Medication records only    \_\_\_ Labs and imaging studies only

\_\_\_ Following specific only: \_\_\_\_\_

### Purpose of Disclosure

\_\_\_ Coordination of care    \_\_\_ Family member access to treatment    \_\_\_ School/college

\_\_\_ Consult/second opinion    \_\_\_ FMLA/Disability    \_\_\_ Transfer of care

\_\_\_ Insurance application (e.g. long-term care)    \_\_\_ Legal (specify): \_\_\_\_\_



\_\_\_\_ Other: \_\_\_\_\_

Print name of Patient or Parent(s)/Legal  
Guardian(s): \_\_\_\_\_

Signature of Patient or Parent(s)/Legal  
Guardian(s): \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_