Montani Mental Health

1137 Van Voorhis Road, Unit 44 Up

Morgantown, WV 26505

Phone: 304-282-0588

Notice of Health Information and Private Practices

The following is a description of how information about you may be used and disclosed and of how you may access your information. Please review it carefully.

At **Montani Mental Health**, we are committed to your treatment and using your protected mental health information responsibly. This notice describes the personal information we collect and how, when, and why we use or disclose your information. This notice is effective August 1st, 2018 and applies to all protected mental health information as defined by federal regulations.

UNDERSTANDNG YOUR MENTAL HEALTH RECORD AND INFORMATION THEREIN

Each time you visit our office, documentation is made regarding your treatment. This record may contain your symptoms, test results, diagnoses, medications, current treatment and a future treatment plan. These are referred to as your mental health record and serves as follows:

- Legal document containing a description of the care you received
- Basis for planning your continued care and treatment
- Means of communication among any health care providers who are or may contribute to your care
- Means by which you or a third-party payer verifies the services billed were provided to you
- An aid in the continued improvement of care by providers in this practice and goals to be achieved
- An information source for public health officials charged with improving the health of this state and nation
- A data source for our planning and marketing
- The correct demographic information used in billing for services rendered

This information will help ensure its accuracy and who, what, when, where, and why others may access your mental health information. It will also help you make more informed decisions when authorizing the release of this information to others.

RIGHTS REGARDING YOUR MENTAL HEALTH INFORMATION

Your mental health record is the physical property of **Montani Mental Health**; however, the information is about you and you have a right to the following:

- Obtain a paper copy of this notice of information and privacy practices upon request
- Inspect your mental health record and obtain a copy as provided under WV State Law (The law for mental health record duplication differs from that of medical health record.) Should you require copies of information regarding your mental health treatment, you will receive a treatment summary letter. Actual records are released only in certain circumstances, such as that of an issued subpoena for such records.
- Amend your mental health record as provided by law
- Obtain an accounting of disclosures of your information
- Request a restriction on certain disclosures of your information
- Request a restriction on certain uses and disclosures of your information except to the extent that action has been taken prior to the effective date of this notice
- Request communications of your information by alternative means or be made through alternative locations.

RESPONSIBILITY OF **Montani Mental Health**

- Provide you with this notice of our legal duties and privacy practices and abide by the terms of this notice
- Maintain the privacy of your mental health information obtained
- Notify you if we are unable to agree to a request made by you to this practice
- Accommodate reasonable requests you may make to communicate your information by alternative means or location

We reserve the right to change our practices regarding the protected mental health information we maintain. If our information and/or privacy practices change, we will make the revisions available to you for review prior to your next visit to our practice.

We will not use or disclose your protected information without your written authorization, except as described in this notice. We will discontinue the disclosure of your information upon written revocation of the authorization according to the procedures included in the authorization.

If you believe your rights have been violated, you may file a written complaint with the Office of Civil Rights. The address for the OCR is as follows:

Office of Civil Rights

US Department of Health and Human Services

200 Independence Ave., SW, Room 509F HHH Bldg.

Washington, DC 20201

EXAMPLES OF DISCLOSURES

We will use your mental health information for treatment.

- Information obtained by a physician, clinician, assistant, or other member of our staff will be recorded in your record. It will be used to determine a treatment plan for you.
- Information will be provided to other health care professionals involved in your care; such as your primary care physician, or to other specialists to assist in treating you when you are referred to or by him/her.

We will use your mental health information for billing purposes.

- A bill may be sent to your or a third-party payer. The information contained on the bill may include information that identifies you, the procedure rendered and your diagnoses.

We will use your information for health care operations.

- Your information may be used to record and maintain the continued improvement of care rendered by our practice.

Business Associated—(Services provided by our practice through contact with outside business associated.)

- This may be necessary to communicate with family members or other persons concerning your care. It is required by law to report when abuse, neglect, or domestic violence is or may be involved; or as required by a court order or administrative order.

Marketing:

- We may contact you to remind you of future appointments or other mental health-related benefits or services that may help or interest you.

The above are only the most common examples of disclosure and use regarding your protected information.

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Financial Policy & Information

The following information is provided to avoid any misunderstanding or disagreement concerning your responsibilities and payment for professional services provided to you.

Prompt payment allows us to control costs. Outstanding accounts cost both the provider and the patient time and money; therefore, all patients will be required to establish a financial arrangement for payment on their account. Any and all co-payments, deductibles, and coinsurance amounts are due and payable at the time of service, unless prior arrangements with our billing department have been made. All patients' accounts are due and payable within 30 days of services rendered. As a courtesy, our practice will establish a monthly payment plan to accommodate your needs.

Please remember that your insurance coverage is an arrangement between you and your insurer. It is your responsibility to communicate with your insurance company regarding past due claims that are unpaid. If a problem occurs with your claim, you will be required to establish written financial arrangements with our office until your insurance problem is resolved. Our office will contact the insurance company on your behalf, however, you are responsible to resolve any dispute regarding unpaid claims.

You will receive a monthly statement showing current dates of service and any balance due from you. We ask that payment be made within 15 days of your statement date, unless prior arrangements have been established. If you are experiencing circumstances beyond your control and are unable to remit payment in a timely fashion, please call our office and we can refer you to our billing department to make financial arrangement which help you resolve any unpaid balances.

Neglecting to remit payment after 61 days of balance due notice or financial agreement will force us to limit future credit until past due balance is settled. All patients will be required to sign a written legal agreement with our practice to alleviate any current delinquency. Please notify us immediately if you feel an error has occurred on your statement. We believe that the provider/patient relationship is based upon understanding and open communication. We have instructed our staff to make every effort available to clarify any misunderstandings or concerns you may have regarding your balance. As a courtesy, our office files claims to your primary insurance on your behalf.

RETURNED CHECKS: *There is a $15.00 charge for any check returned by the bank.*

If this occurs a second time, the amount of the check, plus the return fee must be covered by cash, money order, credit card, or certified check. After the second occurrence, personal checks will no longer be accepted, and any payment will have to be made by using the above methods.

APPOINTMENT CANCELLATIONS/NO SHOWS

Appointments can be made in person or by calling our office. There is no charge for appointments that are cancelled 24 hours in advance of the scheduled appointment time. Patients have the option to cancel by calling our office and speaking directly with a member of our staff, leaving a voicemail, or sending an email to the office email at info@montanimentalhealth.com.

ALL OTHER CANCELLATIONS AND NO SHOWS ARE SUBJECTED TO A $25.00 FEE.

DUTY TO WARN

In the event that the treatment staff reasonably believes that the patient is a danger to themselves or to other people, it is their responsibility to warn the person in danger, in addition to notifying the appropriate medical an law enforcement personnel.

CONSENT TO TREATMENT

I voluntarily agree to receive mental health assessment, care, treatment or services and I authorize the office of Montani Mental Health to provide such care, treatment, or services as are considered necessary or advisable.

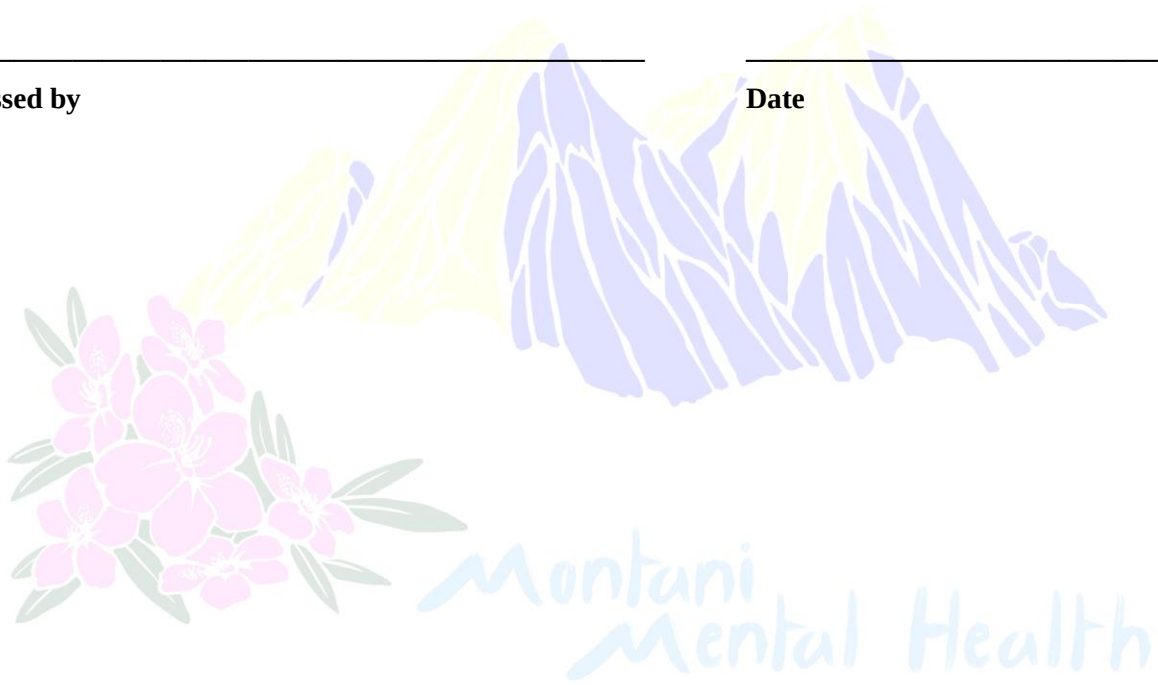
By signing this form, I, the undersigned, acknowledge that I have both read and understand all the terms and information contained herein. Ample opportunity has been offered to me to ask questions regarding anything that is unclear to me.

_____ _____

Signature of patient or responsible party **Date**

_____ _____

As witnessed by **Date**



Acknowledgement of Patient Information & Privacy Practices Notification

I have been made aware of the Patient Information and Privacy Practices Notification. I acknowledge that I have been given the opportunity to review and ask any questions I may have concerning the understanding of such notice. I understand that should the Patient Information and Privacy Practices policy change, that I would be notified. Should time not permit prior notification to upcoming services, I will be informed upon my next visit, prior to any treatment being received.

_____ _____

Patient Name (print) Date

_____

Signature

_____ _____

Witness Date

Acknowledgement of Medicaid/Medicare Policy

Montani Mental Health does not accept any form of Medicaid or Medicare at this time.

I have been made aware and fully understand the Montani Mental Health Medicaid/Medicare Policy.

_____ _____

Patient Name (print) Date

_____

Signature

_____ _____

Witness Date