Inner Peace
Psychological Services and
Integrative Wellness Center, PLLC
www.innerpeacecary.com
Phone: 919.594.6510 Fax: 919-666-0039

Welcome

To Inner Peace Psychological Services and Integrative Wellness center.

Office Policies

Our Office hours are Monday – Thursday 9:00am-6:00 PM and Fridays 9:00–5:00PM as well as some Saturdays from 9:00-3:00PM.

1. Appointments:

- It is the responsibility of the patient to maintain their scheduled appointments schedule.
- If the patient arrives more than 15 min after the start of the appointment, they will not be able to be seen and will need to reschedule.
- If a patient "no shows" their appointment or cancel's their appointment less than 24 hours in advance or two consecutive appointments, then he or she may be referred to another behavioral healthcare practice to continue treatment.

All appointments must be cancelled with 24 hours' notice to Inner Peace Staff. There is a $115.00 charge for appointments that are not cancelled within 24hours' notice, as well as for no show appointments.

2. Medical Records:

- A Protected Health Information Release must be completed by the patient and /or guarantor before any records are released from Inner Peace.
- This includes information from coordinating care with other providers, sharing information with spouses, parents of patients over the age of 18. Please allow 7-10 business days for records to be sent.

3. Confidentiality: Practitioners will not share any personal information without a written consent except when required by law. Practitioners will be required to release in the following situation

- A formal court order to release information is received.
- Child or elder abuse is occurring or there is a reason to suspect that it is occurring.
- A serious threat to harm yourself, others or property is present.
- **As a part of treatment, you will receive a diagnosis, it is required by the insurance company that we provide them with that diagnosis.**

4. Prescriptions:

- If you are in need of a medication refill, be sure to check with your pharmacy first to see if you have any refills left on file. If you have no refills remaining, please call Inner peace and leave a message with the administrative staff.
- Prescriptions cannot be changed vis telephone or email. You must make an appointment for any change in medication.
- Prescriptions requiring prior authorization from insurance can require **an additional 48 hours to complete.**

Please allow 3 business days for prescription refills; DO NOT WAIT UNTIL YOU ARE OUT OF MEDICATION TO REQUEST A REFILL. IMMEDIATE REFILL REQUESTS WILL BE ASSESSED A FEE.

5. Correspondence:

- Due to increases in the amount of records processing and documentation required by many employers, insurance companies and patients, we must impose a fee of $35.00 each for letters emails, forms and phone calls to providers.
- Please allow 10-14 business days for completion of letters and paperwork related to patient care.
- Emails are not HIPAA compliant. Please call the front desk with any concerns you may have.

6. Messages:

- Please leave messages for providers with administrative staff or left in the form of a voicemail on the confidential practice voicemail.
- Please allow the office administrator's 72 hours to return your message.

Inner Peace
Psychological Services and
Integrative Wellness Center, PLLC
www.innerpeacecary.com
Phone: 919.594.6510 Fax: 919-666-0039

7. Insurance:

- Inner Peace is in network with BCBS, CIGNA and MEDCOST.
- Patients without health insurance and patients with an insurance carrier that is out of network will be considered self-pay
- If the patient/guardian should elect to file a claim his or her insurance carrier to seek reimbursement a copy of the required information will be given to the patient.

8. Referrals:

- If an insurance company requires a referral for office visits **it is the patient's responsibility to obtain** this information. Please check with your insurance provider before your visit.

9. Fees / Payment:

- No Show fee is $115.00
- Less than 24-hour cancellation is $115.00
- Letters, Emails and forms are $35.00 each.
- All copays / coinsurance is due at the time of the appointment.
- Payment in full is due at the time of the appointment.
- Inner peace accepts major credit cards, debit cards and cash. **WE DO NOT ACCEPT CHECKS.**
- Patients with deductibles and coinsurance will receive a bill in the mail for any balance that is owed to Inner Peace. Payment is due upon date of bill.
- If the patient is a minor, it is the responsibility of the parent or guardian accompanying the minor for payment.
- If an unaccompanied minor comes in with out written consent by their parent of guardian services will be denied until it is received.
- Inner Pease will assist with a **short-term payment agreement** for the patient to make payments on his or her balance if the patient requests a payment plan. Non-payment of fees can result in termination of services and collection proceedings for out standing patient balances.

A payment agreement form must be filled out in completion by the patient and approved by Inner Peace staff for the agreement to be valid. Please see yellow form in your packet.

Inner Peace

Psychological Services and
Integrative Wellness Center, PLLC
www.innerpeacecary.com
Phone: 919.594.6510 Fax: 919-666-0039

I have read and understand the policies implemented by Inner Peace and agree to abide by them. I also acknowledge that I have read and received a copy of the HIPPA notice of privacy practice.

_____

Print name of patient or guarantor

_____ _____

Signature of patient or guarantor Date:

_____ _____

Witness Signature Date:

Please initial to indicate you read and understand the following sections:

Appointments:	Messages:
Medical records:	Insurance:
Confidentiality:	Referrals:
Prescriptions:	Fees / Payments:
Correspondence:	HIPPA Policy:

Inner Peace Psychological Services and Integrative Wellness Center, PLLC

NOTICE OF PRIVACY PRACTICES - HIPAA (Effective September 10, 2013)

WE ARE COMMITTED TO PROTECTING THE PRIVACY OF YOUR HEALTH INFORMATION. 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 questions about this document or any other questions regarding the privacy of your medical information, please call our office at (919) 782-9554.

OUR PLEDGE REGARDING HEALTH INFORMATION: We are committed to protecting the privacy of health information about you and that can identify you, which we call "protected health information". Protected health information includes information about your past, present or future health, healthcare we provide you, and payment for your healthcare contained in the record of care and services provided by North Raleigh Psychiatry and its medical and administrative staff. Our privacy practices concerning your protected health information are as follows: 1) We will safeguard the privacy of protected health information that we have created or received; 2) We will explain how, when and why we use and/or disclose your protected health information, and 3) We will only use and/or disclose your protected health information as described in this Notice.

HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION: The following categories describe different ways that we may use and disclose your protected health information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within at least one of the categories.

- **For Treatment.** We may use your protected health information to provide, coordinate or manage your health care treatment and related services.
- **Individuals Involved in Your Care or Payment for Your Care.** We may use or disclose your protected health information with a person or persons involved in your medical care or payment for your care, such as a family member or a close friend. We may also notify your family about your location or general condition or disclose such information to an entity assisting in a disaster relief effort.
- **Other Payments.** We may use and disclose your protected health information to other providers, insurance companies, consumer reporting agencies or credit bureaus so they may bill and collect payment for treatment and services they and we have provided to you.
- **For Health Care Operations.** We may use and disclose your protected health information for health care operations. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office.
- **Appointment Reminders.** We may use and disclose protected health information to provide a reminder to you about an appointment you have for treatment or medical care at North Raleigh Psychiatry.
- **Treatment Alternatives.** We may use and disclose your protected health information to manage and coordinate your health care and inform you of treatment alternatives or health-related benefits that may be of interest to you.
- **Research.** Under certain circumstances, we may use and disclose your protected health information for research. Before we use or disclose your protected health information for research, the project will go through a special approval process. Even without special approval, we may permit researchers to look at records to help them identify patients who may be included in their research project or for other similar purposes, as long as they do not remove or take a copy of any protected health information.

SPECIAL SITUATIONS: We may use and/or disclose protected health information about you for a number of circumstances in which you do not have to consent, give authorization or otherwise have an opportunity to agree or object. Those circumstances include:

- **As Required by Law.** We will disclose your protected health information when required to do so by federal, state or local law or other judicial or administrative proceedings. In the event that North Carolina Law requires us to give more protection to your health information than stated in this Notice or required by Federal Law, we will give that additional protection to your health information.
- **To Avert a Serious Threat to Health or Safety.** We may use and/or disclose your health information when necessary to prevent a serious threat your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent or reduce the threat.
- **Business Associates.** We may disclose your protected health information to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.
- **Organ and Tissue Donation.** We may release your protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans.** If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release this information to the appropriate foreign military authorities if you are a member of a foreign military.
- **Workers Compensation.** We may release your protected health information for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your health information to appropriate government authorities for public health activities. These activities include, but not limited to: a) preventing or controlling disease, injury or disability; b) reporting births and deaths; c) reporting child abuse or neglect; d) reporting reactions to medications or problems with products; e) notifying people who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; f) notifying the appropriate government authorities if we believe a patient has been the victim of abuse, neglect or domestic violence; g) To support public health surveillance and combat bio-terrorism. We will only make this disclosure if you agree or when required or authorized by law.

▫ **Health Oversight Activities.** We may use or disclose your protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensures, which are necessary for the government to monitor the health care system and comply with civil rights laws.

▫ **Data Breach Notification Purposes.** We may use or disclose your protected health information to provide legally required notices of unauthorized access to, or disclosure of, your health information.

▫ **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may use or disclose your protected health information in response to a court or administrative order. We may also disclose your health information in response to a subpoena, discovery request or other lawful proves by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

▫ **Law Enforcement.** We may use or disclose your protected health information if asked to do so by a law enforcement official if the information is: a) in response to a court or administrative order, subpoena, warrant, summons or similar process; b) limited information used to identify or locate a suspect, fugitive, material witness or missing person; c) about the victim of a crime, even if, under certain limited circumstances, we are unable to obtain the person's agreement; d) about a death we believe may be the result of criminal conduct; e) about criminal conduct occurring on our premises; f) to be used in an emergency to report a crime, the location of a crime or victims, or the identity, description or location of the person suspected of committing the crime.

▫ **Coroners, Medical Examiners and Funeral Directors.** We may use or disclose your protected health information to a coroner or medical examiner for the purpose of identifying a deceased person or to determine the cause of death. We may also use or disclose your protected health information to funeral directors as necessary for them to carry out their duties.

▫ **National Security and Intelligence Activities.** We may use or disclose your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

▫ **Protective Services for the President and Others.** We may use or disclose your protected health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or to conduct special investigations.

▫ **Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or law enforcement official. This release is required: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; and (3) for the safety and security of the correctional institution.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT AND CHOOSE

▫ ***Individuals Involved in Your Care or Payment for Your Care.*** Unless you object, we may disclose your protected health information to a member of your immediate family, other relative, close friend or any other person you identify that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. *NOTE: If you object, you must inform us in writing and submit it to the Office Manager at the address listed at the top of the first page of this notice.*

▫ ***Disaster Relief.*** We may disclose your protected health information to disaster relief organizations to coordinate your care, or to notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever possible.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written permission. Also, when consent to disclosure is required by state law, your consent will be obtained prior to such disclosure. If you provide us permission to use or disclose your health information, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your health information for the reasons covered by your written authorization. ***We are unable to take back any disclosures we have already made with your permission.*** We are required to retain records of the care that we provided to you.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION: You have to following rights regarding the health information we maintain about you:

▫ **Right to Inspect and Copy.** You have the right to inspect and obtain a copy of your protected health information. To inspect and/or obtain a copy of your protected health information, please call (919) 782-9554 for instructions on how to submit your written request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We will respond to you within 30 days of receiving your written request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit

program. There are certain circumstances in which we are not required to comply with your request. Under these circumstances, we will respond to you in writing, stating why we will not grant your request and describing any rights you may have to request a review of our denial. The person conducting the review will not be the person who denied your original request. We will comply with the outcome of the review.

▫ **Right to an Electronic Copy of Electronic Medical Records.** If your protected health information is maintained or stored in an electronic format (also known as EMR-Electronic Medical Record or EHR-Electronic Health Record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. We will make every effort to provide access to your protected health information in the form or format you request, if it is readily producible in such form or format. If the information is not readily producible in such form or format that you request, your information will be provided in our standard electronic format. If you do not want this form or format, your information will be provided in a readable hard copy form. We may charge you a reasonable fee for the labor associated with transmitting the electronic medical record.

▫ **Right to Get Notice of a Breach.** You have the right to be notified upon a breach of any of your protected health information.

▫ **Right to Amend.** You have the right to request that we make amendments to clinical, billing and other records used to make decisions about you or your health care. Your request must be in writing and must explain your reason(s) for the amendment. We may deny your request if: a) The information was not created by us, unless the person or entity that created the information is no longer available to make the amendment; b) The information is not part of the health information used to make decisions about you; c) We believe the information is correct and complete; d) You would not have the right to inspect and copy the record as described above. We will tell you in writing the reason(s) for the denial and describe your rights to give us a written statement disagreeing with the denial. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including persons you name that have received your protected health information. Please submit your request for amendment in writing to: North Raleigh Psychiatry, 5530 Munford Road, Suite 119, Raleigh, NC 27612. Your written request should include your full name, date of birth and any other pertinent information needed to identify your record.

▫ **Right to an Accounting of Disclosures.** You have the right to receive a written list of certain disclosures we made of your protected health information for purposes other than treatment, payment and health care operation or for which you provided written authorization. This does not include any disclosures made before April 14, 2003 and is limited to disclosures made within the last six (6) years. If you request this accounting more than once in a 12-month period, we may charge a reasonable cost-based fee for responding to the additional requests. To request this list or accounting of disclosures, you must submit your request in writing to: North Raleigh Psychiatry, 5530 Munford Road, Suite 119, Raleigh, NC 27612. Please include your full name and date of birth with your written request.

▫ **Right to Request Restrictions.** You have the right to request that we restrict or limit the use and disclosure of your protected health information with regards to treatment, payment or health care operations as well as disclosure to someone involved in your care or payment for your care. We are not required to agree to your requested restrictions unless you are asking us to restrict the use and disclosure of your protected health information to a health plan for payment or health care operation purposes, and such information you wish to restrict pertains solely to a health care item or service for which you have paid us "out-of-pocket" in full. If we agree, we will comply with your request unless the information is needed a) to provide you with emergency treatment, b) for disclosure to the Secretary of the Department of Health and Human Services and/or c) uses and disclosures that do not require your authorization. You may request a restriction by submitting the request in writing to: North Raleigh Psychiatry, 5530 Munford Road, Suite 119, Raleigh, NC 27612. Please include your full name and date of birth with the request.

▫ **Right of Refusal to File Insurance.** If you have paid out-of-pocket in full for a specific item or service that we have provided, you have the right to ask that your protected health information not be disclosed or shared with a health plan for purposes of payment or health care operations with respect to that item or service, and we will honor that request.

▫ **Right to Request Alternative and/or Confidential Communications.** You have the right to request how and where we contact you about your protected health information. Your request must be in writing. We will accommodate reasonable requests, but when appropriate, may condition that accommodation on your providing us with information regarding how payment, if any, will be handled and your specification of an alternative address or other method of contact. You may request alternative means of communications by submitting a written request to: North Raleigh Psychiatry, 5530 Munford Road, Suite 119, Raleigh, NC 27612. Please include your full name and date of birth on the request.

▫ **Right to a Paper Copy of This Notice.** You have a right to a paper copy of this notice at any time. You may obtain a copy of this notice on our website at www.nrpsych.com, under the "Office Information" section. To request a paper copy of this notice, you may visit our office located at 5530 Munford Road, Suite 119, Raleigh, NC 27612.

CONTACT FOR QUESTIONS OR COMPLAINTS

If you have any questions regarding this Notice or if you believe your privacy rights have been violated or you wish to file a complaint about our privacy practices, you may contact the Office Manager by telephone at (919) 782-9554, or in writing at North Raleigh Psychiatry, 5530 Munford Road, Suite 119, Raleigh, NC 27612. Please provide your full name and date of birth with your request/complaint. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

CHANGES TO THIS NOTICE

We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by: 1) Posting the revised notice at our facilities; and/or 2) Making copies of the revised notice available upon request (either at our facilities or through the contact listed in this notice

Inner Peace
Psychological Services and
Integrative Wellness Center, PLLC
www.innerpeacecary.com
Phone: 919.594.6510 Fax: 919-666-0039

Contact for Questions or Complaints:

If you have any questions regarding this notice or if you believe your privacy rights have been violated or wish to file a complaint about our privacy practices, you may contact the Practice Manager by telephone at (919) 594-6510, or in writing to Inner Peace Psychological Services & integrative Wellness Center, PLLC at 102 Towerview Court Cary, NC 27513. Please provide your full name and date of birth with your request / complaint. You may also send a written complaint to the United States Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Changes to This Notice:

We reserve the right to change the terms of this notice and to make new notice provisions effective for all protected health information that we maintain by: 1) Posting the revised notice at our facilities; and / or 2) making copies of the revised notice available upon request (either at our facilities or through the contact listed in the notice).

Please sign to acknowledge that you have read and have received a copy of this Notice of Privacy Practices-HIPPA

_____ _____

Signature of patient or Guarantor **Date**

Inner Peace

Psychological Services and
Integrative Wellness Center, PLLC
www.innerpeacecary.com
Phone: 919.594.6510 Fax: 919-666-0039

Patient Demographics

Patient's name(First Middle Last):				Preferred name:	
Date of Birth(MM/DD/YYYY):			Social Security Number:		
Address:				Apt#:	
Apt#	Zip Code:	City:		State:	
Home Phone:			Mobile Phone:		
Okay to Leave a message:				YES	NO
Email Address:			Okay to Email:	YES	NO
Marital Status:	Ethnicity:		Race:	Gender:	
	Patient Declined:		Patient Declined:		
Employer Name:			Employment Status:		
Parent/Legal Guardian Name:			Relationship to Patient:		
Address Street:				Apt#:	
City:	State:	Zip Code:	Primary Contact #:		
Emergency Contact Name:		Relationship:	Contact Number:		

People With Whom My Health Information Can Be Shared *(Please include the emergency contact person)*

1._____ 2._____

3._____ 4._____

What information can we share with those listed above?

◯ Financial/Billing	◯ Medications, changes and directions for use
◯ Laboratory/Blood Test	◯ Diagnosis/Treatment Plans

Name of Insurance:	Relationship to Patient: ◯ Self ◯ Spouse ◯ Child
Policy Holder Name:	Policy Holder DOB:
Policy Number:	Group Number:

ALL INSURANCE INFORMATION MUST BE COMPLETE AND ACCURATE

Missing or inaccurate information will result in non-payment from your insurance company. The insurance company will be billed as a courtesy by this office. Payment of benefits will be made to Inner Peace Psychological Services for services rendered. Should your insurance company refuse payment, you will be notified. Patients notified of non-payment are expected to contact their insurance company to resolve any problems.

YOU MUST BRING YOUR MOST CURRENT INSURANCE CARD AND PHOTO ID TO EVERY APPOINTMENT

I UNDERSTAND THAT I WILL PAY ANY DEDUCTABLE AND/OR ANY CO-PAYMENTS AT TIME OF SERVICE YOUR INSURANCE COMPANY DETERMINES THIS AMOUNT.

Patient/Responsible Party Signature: Date:

Pharmacy for Prescription Medication

Pharmacy Name:	Location:	Mail Order Pharmacy:

How did you learn about our practice?

Patient Name:	Date of Birth:
Reason for Appointment:	
Have you been hospitalized in the past year? No Yes Date: Reason:	
Medical Provider:	Phone:
Primary Care:	Phone:

Have you ever had any of the following medical conditions?

○ Seizures, Epilepsy	○ Heart Disease / Heart Attack, Date:
○ Head Trauma, Loss of Consciousness	○ High Cholesterol
○ Acid Reflux	○ Diabetes, Pre-Diabetes
○ Irritable Bowel Syndrome	○ High Blood Pressure
○ Migraine Headaches	○ Low Thyroid, High Thyroid
○ Chronic Sinusitis	○ Stroke or TIA (mini-stroke) Date:
○ HIV	○ Chronic Pain
○ Hepatitis B or Hepatitis C	○ Cancer, What Form: Date:
○ Vitamin Deficiency	○ Kidney Disease
○ Vitamin B12 Deficiency	○ Pituitary Tumor

Other:

Current Medications-Please include over the counter vitamins and supplements

Medication Name	Pill Strength	Frequency	Reason

Medications you are allergic to

Medication name	Reaction

Surgical History

Surgery	Date	Reason

Are you a Diabetic?	○ Yes	○ No	Years Treated:	
○ Good Control	○ Poor Control		Last Blood Sugar:	HgA1C: %

Social History

Alcohol	○ Present	○ Past	Amount / Frequency:
Cigarettes	○ Present	○ Past	Amount / Frequency:
Marijuana	○ Present	○ Past	Amount / Frequency:

Other:

Have you ever received treatment for Alcohol or Sustance Addiction? If so, where and when?

Patient Name:	Date of Birth:
Have you ever experienced head trauma or a concussion? If yes, when and how?	

Past Psychiatric Treatment

Hospitalizations	Date:	Name of Hospital:	
Suicide Attempts	Date:		
Self - Harm	○ Past	○ Current	Frequency:
Other Information:			

Issue	YES	NO	Details
General/Constitutional *(fever, heat stroke, weight loss, weight gain, unusually tired.)*			
Ear, Nose, Throat,(*hard of hearing, stuffy nose,earaches,cough,dry mouth, etc..)*			
Respiratory *(congestion,wheezing,short of breath, etc..)*			
Cardiovascular *(high BP, low BP, racing pulse, etc.)*			
Gastrointestinal*(upset stomach, diarrhea, constipation,hernia,ulcers,etc.)*			
Genital, Kidney Bladder *(painful or frequent urination,impotence,yellow jaundice.)*			
Skin *(pimples, warts, growths, rash, etc..)*			
Endocrine (*diabetes Type 1 of 2, hypothyroid? Has your appetite changed?)*			
Neurological (*numbness, headache, seizures, paralysis, etc.)*			
Psychiatric (*anxiety, depression, insomnia etc.)*			
Muscle, Bone, Joints (*joint pain, stiffness,swelling,cramps, arthritis etc.)*			
Blood / Lymph *(Bleeding, cholesterol, anemia, problems related to blood transfusions, etc..)*			
Allergic / Immunologic *(Sneezing, swelling, redness, itching, hives, lups etc.)*			
Females *(Are you pregnant or nursing)*			
Eyes *(poor vision, eye pain, tearing redness etc.)*			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Inner Peace or my insurance company to release any information required to process my claims.

Patient or Guardian Signature:	Date:

INNER PEACE PSYCHOLOGICAL SERVICES AND INTEGRATIVE WELLNESS CENTER, PLLC

Payment Authorization Form

Inner Peace Psychological Services and Integrative Wellness Center, PLLC is unable to finance or carry patient balances. Inner Peace requires all patients to keep a credit card on file. If you choose not to leave a credit card on file, Inner Peace requires a $200 deposit. If you choose to transfer to a different mental health provider, and all claims and balances are paid in full, the $200 deposit will be refunded when the practice is informed in writing that you are transferring care.

Here's How Recurring Payments Work:

You authorize ANY PATIENT BALANCE (Deductible, co-insurance, co-pay, No Show $115 and same day cancellation-less than 24 hrs), charges to your credit card. You will be charged the amount indicated below at the time of service. A receipt for each payment will be mailed to you and the charge will appear on your bank statement as an "ACH Debit." You agree that no prior-notification will be provided. For your security, credit card forms will be kept in a locked secured location.

Please complete the information below:

I _____ authorize **INNER PEACE PSYCHOLOGICAL SERVICES AND INTEGRATIVE WELLNESS CENTER, PLLC** to charge my credit card, indicated below, for **PATIENT'S COPAYS/DEDUCTIBLE/COINSURANCE** and any **ACCOUNT BALANCES FROM NO SHOWS ($115)/SAME DAY CANCELLATIONS($115).**

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

CREDIT CARD ON FILE

☐ Visa ☐ MasterCard

☐ Amex

Cardholder Name _____

Account Number _____

Exp. Date _____

CVV (3 digit number on back of card) _____

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify INNER PEACE PSYCHOLOGICAL SERVICES AND INTEGRATIVE WELLNESS CENTER in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. For ACH debits to my checking/savings account, I understand that because these are electronic transactions, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non Sufficient Funds (NSF) I understand that INNER PEACE PSYCHOLOGICAL SERVICES AND INTEGRATIVE WELLNESS CENTER may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this credit card/bank account and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.