CATAWBA COMMUNITY MENTAL HEALTH
ADULT OUTPATIENT SERVICES
PATIENT INFORMATION / CONTRACT FOR SERVICES

Welcome to, the Catawba Community Mental Health Center. This document contains important information about our services and our business policies. Please let us know If you have any questions after you read the document and have everything explained to you.

PARTICIPATION IN SERVICES: Services vary depending on your needs. Your Plan of Care is individualized based on your needs, and when you sign the Plan of Care, it is viewed as a "contract" between you and your therapist.

APPOINTMENTS: We recognize that there are times when you cannot keep a scheduled appointment, but please give us at least 24 hours' notice if you need to cancel for any reason. If you fail to keep scheduled appointments or cancel appointments with little notice, your Clinician may have a discussion with you regarding your plan of care.

MEDICATION REFILL REQUESTS: Please give us 1 to 2 weeks' notice before you run out of any of the medications that are prescribed for you here at the clinic. We ask this because many insurance companies require an authorization request from us before they will pay for your medicine. This can be a lengthy process. Our nurses will call you back within 48 business hours of your request to update you.

CONSENT FOR MEDICATION PICK-UP: We understand that you may not be able to pick up medications that are prescribed for you here at the clinic. However, you can identify someone to pick up your medications for you. Please list two people who have your permission to pick up your medicine. Please tell them that we cannot give them your medicine unless they have a picture ID and are' listed on this form.

NAME OF DESIGNATED PERSON	DATE OF BIRTH	RELATIONSHIP TO PATIENT

PAYMENT FOR SERVICE: Payment for treatment is expected at the time of your office visit. If you have insurance coverage, **it is your responsibility to pay the remaining balance of what your insurance will not cover**. If insurance coverage requires a co-pay, this payment is required at the time of your office visit. If you have questions regarding your financial obligation, please discuss them with your clinician or contact the business office.

CONFIDENTIALITY: Your Protected Health Information will be maintained in accordance with applicable federal and state laws, rules, and regulation which authorize disclosure in certain circumstances including but not limited to the following: other medical providers, insurance companies, Medicaid/Medicare, and family involvement in treatment. We may phone you with reminders of appointments to follow up regarding services and satisfaction surveys. Please let us know if you have any special requests or restrictions on how you want us to share information or communicate with you.

______________________________ ______________________
Patient Name, PRINT **CID #**

______________________________ ______________________
Patient Signature **Date**

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Therapist Name, PRINT

______________________________ ______________________
Therapist Signature **Date**