



SUNPOINTE HEALTH

320 Rolling Ridge Drive, Suite 100, State College, PA 16801 • Phone: (814)867-0670 • Fax: (814)867-7616

Patient Registration

Patient Name: _____ Today's Date: ____/____/____

Date of Birth: ____/____/____ Age: ____ Gender: ____ Marital Status: _____ Account #: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Phone # – Home: (____) _____ - _____ Work: (____) _____ - _____ Ext _____

Cell: (____) _____ - _____

Please indicate your preferred phone number for automated appointment reminder calls (select one):

Home Work Cell Text reminders (must have cell number) I do not want reminder calls

Billing Address – Street: _____ City: _____

State: _____ Zip: _____

Local Mailing Address - Street: _____ City: _____

State: _____ Zip: _____ (PSU Students)

Emergency Contact Information

Name: _____

Relationship to Patient: _____

Phone Numbers – Home: (____) _____ - _____ Work: (____) _____ - _____ x _____

Cell: (____) _____ - _____

Primary Care Provider

Name and Address of Primary Care Provider:

Phone: (____) _____ - _____ Fax: (____) _____ - _____

Release for Appointment/Financial Information

By signing below, I authorize the providers and staff of SunPointe Health to release information regarding my appointment dates and times and/or financial information with the person(s) listed below. I understand that by signing this release, and checking the applicable box(es) the designated person(s) will 1) be able to speak to any member of SunPointe Health regarding my appointments and may schedule or change appointments on my behalf and/or 2) be able to speak to staff regarding my account balance and billing information. **This authorization pertains only to appointment and financial information.** In order to release any further information to the person(s) named below, a full release of information must be completed. If at any time you wish to revoke this release, you must provide written notification to our office.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Patient (or Parent/Guardian if under age 14): _____

Date: ____/____/____



Patient Name _____ Date of Birth _____

Health Insurance Information: (Please complete all sections and to give receptionist a copy of all cards)

Primary Health Insurance Plan- Plan Name: _____
Ins. ID #: _____ Policy Holder Information: Self - Other
(Name: _____ SS#: _____ - _____ - _____ Birthdate: ____/____/____)

Secondary Health Insurance Plan- Plan Name: _____
Ins. ID #: _____ Policy Holder Information: Self - Other
(Name: _____ SS#: _____ - _____ - _____ Birthdate: ____/____/____)

Assignment of Benefits:

I hereby request that payment of authorized **Medicare, Medicaid, and all other insurance** benefits be made on my behalf to SunPointe Health for any services provided to me (or my child/my ward). I authorize any holder of my (or my child's/my ward's) medical record information to release information to the appropriate entity and its agents in order to determine these benefits payable for related services

Signature of Patient (or Parent/Guardian if under age 14): _____

Date: ____/____/____

Consent for Use and Disclosure of Protected Health Information:

Identifiable healthcare information about you (Protected Health Information) may be used or disclosed to carry out treatment, payment, or healthcare operations. The terms of this notice may change, and you may request a revised notice in person, by phone, in writing, or at our website at www.forabrighterfuture.com. Changes are made from time to time to comply with state and federal law and professional ethical guidelines.

▪ You have the right to request restrictions in the use or disclosure of your Protected Health Information. Your clinician(s) at SunPointe Health are not required to agree to the requested restrictions if these are not seen as being in your best interest but are required to explain their reasons to you. Once agreed to, any requested restrictions must be honored.

▪ You may revoke your consent to release this information at any time by providing this request in writing to your clinician or the Health Information Management department. Changing this consent will not apply to uses and disclosures that have already occurred.

▪ If you are treated by a member(s) of **Susquehanna Valley Professional Associates**, your Protected Health Information may be shared within this group, as necessary, for coordination of care, coverage in your clinician's absence, and consultation

▪ You have confidentially right. However, confidentially does not apply under certain situations: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else. Except in these rare situations, your child has the right to keep particular topics confidential from even his/her guardian. Please respect this confidentiality. Again, if there is any concern of harm, suicide or other dangerous behavior, we will inform you.

Receipt of Notice of Privacy Practices Written Acknowledgement Form:

I, _____, have received a copy of SunPointe Health's Notice of Privacy Practices and Patient Handbook.

Signature of Patient (or Parent/Guardian if under age 14): _____

Date: ____/____/____



Patient Name _____ Date of Birth _____

Consent for Treatment:

You are about to take a very important step in your mental health treatment, and you are seeing a mental health professional. As your mental health provider, we are entering into a protected relationship.

- I understand that Sunpointe Health is an outpatient, appointment-only facility. During my initial appointment, I will review a crisis plan with my provider if needed. I acknowledge that Sunpointe Health does not provide emergency services. If I ever feel unsafe or experience a crisis, I agree to call 911 or go to the nearest emergency room for immediate assistance.
- We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with normal emotional development. This may include recommendations for therapy, or medications. This is all part of the service of a mental health professional. We will also work with your primary care physician to assure coordination of care.
- To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, patients that have not been seen in 6 months may be considered inactive. A New evaluation will be required for any inactive patient to be seen.
- I am aware that I may stop treatment with this mental health professional at any time. I understand that I may lose services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court ordered, I will have to answer to the court)
- I understand that I may not record any part of my session without written consent from my provider.
- I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the internet, my information may not be completely secure. In the event that my information is intercepted, Sunpointe health is not responsible for the breach of patient privacy.

I hereby seek and consent to participate in treatment provided by SunPointe Health. I understand that it is in my (or my child's/ward's) best interest to develop a treatment plan with my provider and to regularly review progress toward treatment goals. I agree to take an active role in this process and acknowledge that no guarantees have been made regarding the outcome of treatment, or any procedures provided.

I also authorize the use and disclosure of my (or my child's/ward's) medical record information—which may include mental/behavioral health, HIV/AIDS status, sexually transmitted diseases, and/or drug and alcohol use or dependency—pursuant to applicable federal and state laws. This information may be shared with third-party payers and other healthcare providers involved in my care for the purposes of treatment, payment, or healthcare operations, as outlined in the Notice of Health Information Privacy Practices. This consent is required for participation in treatment.

Signature of Patient (or Parent/Guardian if under age 14): _____

Date: ____/____/____



Patient Name _____ Date of Birth _____

Consent for Telehealth:

Telepsychiatry is the delivery of psychiatric services using an interactive audio and visual electronic system where the provider and patient are not in the same physical location. A full version of requirements, benefits versus risk, patient’s right and responsibilities is available upon request.

Patient Rights and Responsibilities:

- I have the right to withhold or withdraw my consent to the use of telepsychiatry during the course of treatment at any time. This withdrawal of consent will not affect any future care and/or treatment.
- I understand that my provider has the right to withhold or withdraw his or her consent for telepsychiatry during the course of my care at any time.
- I understand that the provider will not allow any other individual to listen, view or record my sessions without my written permission.
- I will not record any telepsychiatry session without written consent from my provider. I will inform my provider if another person can hear or see any part of our session.
- I understand that I, not my provider, am responsible for the configuration of any electronic equipment used on my computer. It is my responsibility to ensure proper functioning of all electronic equipment prior to the start of my session.
- I understand that I must be in the state of Pennsylvania to be eligible for telepsychiatry services from SunPointe Health.
- I understand that a telepsychiatry appointment is scheduled the same as an office appointment would be and should I not be available for the appointment or cancel with less than 24 hours notice, it will be charged as a no show/late cancel appointment.

I understand that if I don’t sign the consent all my treatment will be conducted in person and I will not be allowed to change any appointments to telehealth until a consent is signed.

I have read and understand that all clinic policies of SunPointe Health apply to all telepsychiatry and in person visits.

Signature of Patient (or Parent/Guardian if under age 14): _____
Date: ____/____/____



Patient Name _____ Date of Birth _____

A **financial guarantor** is the individual responsible for paying all charges associated with the patient's care. This includes all fees, copayments, deductibles, and other related expenses.

Financial Policy:

- ❖ I understand that verifying my insurance benefits is ultimately my responsibility. Although SunPointe Health's billing department may provide benefit estimates as a courtesy, these are not guarantees of payment. Final coverage decisions are made by my insurance provider, and I agree to be financially responsible for any uncovered charges. I also understand that billing my insurance is offered as a courtesy and does not relieve me of my financial responsibility for services received.
- ❖ I understand that it is my responsibility to ensure that my demographic information is accurate and up to date. If claims are denied or cannot be submitted due to outdated or missing demographic information, I acknowledge that the visit will be billed to me as a self-pay patient until the necessary updates are made. I also understand that insurance companies have strict timely filing deadlines, which vary by plan, and that failure to provide accurate information in time could result in my claim being denied and me being held responsible for the full cost of the visit.
- ❖ I understand that in order for SunPointe Health to properly bill my insurance, I must notify the office of any changes to my insurance plan before the day of my appointment. If I fail to provide updated insurance information in advance, I understand that I will be considered a self-pay patient until my new plan can be verified and confirmed to be in-network. I acknowledge that same-day verification may not be possible, and I may be responsible for payment at the time of service.

Rate and Fee Schedule:

- ❖ I understand that all copays are due at the time of service. For telehealth appointments, I must have a credit card on file, and I consent to having my card charged by the office staff on the date of my appointment. If the card is declined or the copay is not paid, I understand that my upcoming appointment may be canceled or converted to an in-person visit. Continued failure to pay copays on time may result in my ineligibility for telehealth services.
- ❖ I understand that if my insurance plan includes a deductible, I will be required to pay a flat portion of the visit cost prior to my appointment. I acknowledge that this amount is an estimate, and additional charges may be billed after the claim is processed. I also understand that if I overpay due to having met my deductible, the excess amount will either be applied to future visits or refunded if I do not plan to return. For telehealth visits, I must have a credit card on file, and payment must be made on the date of the appointment. If payment is not received, my following appointments may be canceled or changed to in-person.
- ❖ I understand that the office reserves the right to hold or delay treatment if my account balance exceeds \$400, even if I have been making regular payments. I further acknowledge that if my account remains unpaid for more than 90 days, SunPointe Health may terminate my treatment.
- ❖ I understand that SunPointe Health is willing to provide assistance if the financial burden becomes too high or difficult to manage. It is my responsibility to contact SunPointe Health to request this assistance **before** my account balance reaches \$400 and/or becomes more than 90 days past due with no payments. I understand that if my balance exceeds these limits, it is my responsibility to bring the account current in order to continue receiving care at SunPointe Health. Billing may be reached at 814-867-8511.



Patient Name _____ Date of Birth _____

Self-Pay Policy:

I understand that if I am paying out of pocket and make full payment on the day of my visit, I will receive a 20% discount. If I am unable to pay at the time of service, I will be required to pay a flat fee prior to the visit, and the remaining balance must be paid in full before my next appointment.

Service	Fee
No Show	\$70
Late Cancellation	\$45
Returned Check Fee	\$40
Base Rate for Self-Pay	\$76
Base Rate for Deductible	\$75

Clinical Policy:

- I understand that Sunpointe Health requires that all appointments be cancelled no later than 24 business hours before the appointment is scheduled (Monday through Friday 8:00 am to 4:30 pm, excluding holidays).
- I understand that if I no-show or cancel an initial evaluation with our clinic with less than 24 business hours' notice, my file may be closed.
- I understand that I will be allowed 3 (three) late cancellations in a 12 month period. If this number is exceeded, I understand that my file may be closed.
- I understand that I will be allowed 3 (three) no-shows in a 12 month period. If this number is exceeded, I understand that my file may be closed.
- I understand that if I have commercial insurance I will be charged \$70 for any no-show appointment
- I understand that it is my responsibility to call the office at (814) 867-0670, or via our appointment reminder system, to cancel any appointment.
- By initialing I acknowledge that I have read, understand and will abide by the above policies and that if I do not, my file with Sunpointe Health may be closed.

I understand that as the financial guarantor, I am responsible for all charges not covered by my insurance. This includes, but is not limited to, copays, coinsurance, deductibles, fees and services not covered by my plan.

Printed Name of Financial Guarantor (Must be 18 or Older): _____

Guarantor Signature: _____ **Date:** ____/____/____

Relationship to Patient: _____ **Phone #:** _____ **D.O.B:** ____/____/____

Address - Street: _____ **City:** _____

State: _____ **Zip:** _____



Account # _____

Credit Card Authorization

Per Sunpointe Health guidelines, a valid credit card is required to be kept on file for all accounts. This information will be stored securely in accordance with industry standards. You will always have the option to pay any fees using an alternative payment method, provided payment is made in a timely manner.

Charges to the credit card on file may be applied under the following circumstances:

Copay Policy - Copays are due on the date of service, in accordance with your insurance plan requirements. You may present an alternative method of payment prior to or at the time of your appointment. If no other method of payment is provided by the date of service, the credit card on file will be charged for the copay. **Please note** that statements will **not** be mailed for copays, as they are due at the time services are rendered. In the event that the card on file is not successfully charged at the time of service—due to error, oversight, or card issue—the charge will be processed before any statements are mailed.

Co-Insurance and Deductible Policy - For patients with deductible-based insurance plans, a flat rate will be collected at each visit until the deductible is met. This amount is an estimate and may not reflect the final balance. The credit card on file will be charged for this flat rate in the same manner as copays. Once the deductible has been met, any remaining balances due to co-insurance or differences from the estimated flat rate will be billed. A statement will be mailed outlining the exact amount owed. You will have 45 days from the date of the statement to submit payment using an alternative method. If no payment is received within that time, the balance will be charged to the credit card on file.

Late Cancellation and No-Show Charges - In accordance with policy, charges will be applied for late cancellations or missed appointments without proper notice. A statement will be sent detailing the charges. You will have 45 days from the date of the statement to submit payment using an alternative method or to dispute the charge. If no payment or dispute is received within that time frame, the balance will be charged to the credit card on file.

Personal Payments on Account Balances - Patients are welcome to make monthly payments on past due balances. As long as regular payments are being made, we will not charge the credit card on file. However, if no payment is made within 30 days, the credit card on file will be charged for any balance that is more than 45 days past due, provided statements have been sent.

Please note: Copayments made at the time of service do not count as payments toward past due balances.

Use of HSA/FSA/HRA Cards - If you choose to provide a Flex Spending Account (FSA), Health Savings Account (HSA), or Health Reimbursement Arrangement (HRA) card as your credit card on file, please be aware that you are solely responsible for determining which charges are eligible under your plan. Sunpointe Health will not be responsible for denied charges, or any issues related to ineligible expenses on these types of accounts.

Credit Card Validity Notice - If the credit card on file expires, becomes invalid, or is declined due to insufficient funds, you will be required to update your credit card information and/or pay any outstanding balance in full **before** you are able to reschedule with your provider.

I authorize Sunpointe Health to securely store my credit card information and to charge my credit card as outlined above. I understand that I will be notified of any charges and have the opportunity to use another form of payment within the stated time frames. I have read and understand the policies outlined in this form.

Patient Name (printed): _____ Patient Date of Birth: ____/____/____

Card Type (circle one): Visa MasterCard Discover

Name on Card: _____ Date: ____/____/____

Card Holder Signature: _____ Billing Zip code _____

Credit Card Number: _____ EXP Date: ____/____/____

Email address for receipts (please write legibly): _____