Jolyn Zeller, RN, MS, PMHNP-BC, d.b.a. *Solarity Mental Health, PC*
River Rd Plaza Suite A, 3787 River Rd N, Keizer OR 97303
Tele: 503-763-1778 Fax: 503-980-7888
http://www.solaritymentalhealth.com
Appointments 971-225-5505

Registration, Fee Agreement, and Consent

(please make sure to sign both)

Patient Information

LAST NAME: _____FIRST NAME:_____MIDDLE INITIAL: _____

DOB (MM/DD/YYYY): _____ /_____/_____ GENDER _____ ETHNICITY_____

STREET ADDRESS: _____ APARTMENT #_____

CITY_____STATE_____ZIP_____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): _____

CITY_____STATE_____ZIP_____

HOME PHONE: (_____)-_____-_____ MESSAGE OK? ___YES___NO CELL PHONE: (_____) _____-_____

EMAIL _____

School Attending: _____ Grade_____

Primary care: _____ Phone: _____

Therapist:_____ Phone:_____

Parents/Guardian:_____

Emergency contact:_____ Phone: _____

Billing Address: COMPLETE FOR ADULT RESPONSIBLE FOR PAYMENT OF CHARGES NOT COVERED BY INSURANCE

LAST NAME: _____FIRST NAME:_____MIDDLE INITIAL: _____

AKA if know another name : _____

DOB (MM/DD/YYYY): _____ /_____/_____ SSN: _____-_____-_____ DRIVERS LICENSE _____
State

STREET ADDRESS: [ ] same as above _____ APARTMENT #_____

CITY_____STATE_____ZIP_____

MAILING ADDRESS (IF DIFFERENT THAN ABOVE): _____

CITY_____STATE_____ZIP_____

HOME PHONE: (_____)-_____-_____ MESSAGE OK? ___YES___NO CELL PHONE: (_____) _____-_____

WORK TELEPHONE NUMBER: (_____)-_____-_____ MESSAGE OK? ___YES ___NO

Insurance Information (clients name)_____

The primary insurance is usually based on the earliest birthday of the subscribers.

PRIMARY INSURANCE._____

ADDRESS: _____ PHONE:_____

EMPLOYER:_____

SUBSCRIBER/MEMBER NAME: _____ DOB: _____

SUBSCRIBER ID # _____ GROUP/POLICY # _____

RELATIONSHIP TO PATIENT/CLIENT: _____

SECONDARY INSURANCE:_____

ADDRESS: _____ PHONE:_____

EMPLOYER:_____

SUBSCRIBER/MEMBER NAME: _____ DOB: _____

SUBSCRIBER ID # _____ GROUP/POLICY # _____

RELATIONSHIP TO PATIENT/CLIENT: _____

You should check with your insurance company to find out your benefits and responsibilities including if you have a deductible and the amount of your co-pay. Please be prepared to pay your co-pay and deductible if applicable at the time of the visit.

~~ FEE AGREEMENT ~~

I (print name) _____ understand that I am responsible for any communication or prior authorization with my insurance company. I understand that the established fee for services with *Solarity Mental Health, PC* includes office visits, client telephone contacts, and professional consultations on the client's behalf. The established fees for services based on the complexity of the case. Phone consultations may not be covered. I am also responsible if I fail to show up for an appointment. **The no show fee is 75.00.** To avoid being charged, appointments maybe cancel at least **24** hours in advance.

Solarity Mental Health, PC will bill my primary insurance, and my secondary insurance for preferred companies. Note Solarity Mental Health, PC is not paneled with Oregon Health Plan. Any outstanding balance not covered by insurance will be billed to me at the specified billing address. A **$5.00** *rebilling fee* will be added for any outstanding balances beyond 30 days of the billing date and for subsequent billing. Checks written with *insufficient funds* will be charged a **$30.00** fee in addition to the bank charges. I understand that if I do not follow this agreement, Jolyn Zeller reserves the right to deny services, and pursue collection.

I authorize this office to release any information necessary to expedite insurance claims to the insurance companies listed above, or to any subsequent insurers should my health insurance change. This includes information about psychiatric treatment and/or drug and alcohol treatment. This will include my diagnosis and for some insurers may also include my treatment plan or the full text of my chart. I hereby consent the fee agreement and take responsibility to pay for treatment. A copy of this agreement is available at *http://solaritymentalhealth.com.*

SIGNATURE of Responsible Adult: _____ DATE:_____

~~ INFORMED CONSENT FOR TREATMENT ~~

Clinical records are kept under the strictest rules of confidentiality, which means that information about your treatment will not be released to any outside agency or individual without your written permission. Please be advised, however, that rules of confidentiality will be broken under certain circumstances as Nurse Practitioners are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse and evidence of past or current elder abuse. Additionally, confidentiality may be broken in the event that the information we have could help save your life in a life-threatening emergency. If you have questions about confidentiality, please feel free to ask. The notice of privacy practices is available on my web site at **http://solaritymentalhealth.com** or you may request a printed copy. It is best to coordinate treatment with your primary care provider. As a child provider, I will asked that a parent or guardian is included in treatment decisions in most cases, however for clients over the age of 14 this is your choice.

You should know that sometimes symptoms become worse before they become better, though this should subside as the work of treatment progresses. Think of it as cleaning a wound. Some treatments can have adverse reactions. I may ask you to do tasks outside the office visit such as tracking symptoms. Treatment results are often a result of the effort applied. You may also be asked to have laboratory work or EKG screens outside of my office. I may request screening for drugs of abuse or do pregnancy testing. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. Your treatment will be based on your symptoms and functioning and reviewed at your appointments. You have the right to be informed of your mental health diagnosis after the mental health assessment is completed, and the purpose of any prescribed medication and potential side effects. It is my contention that for children a diagnosis is based on functioning and symptoms at a particular point in time and is subject to change as the child develops. You should understand that many medications are not FDA approved for children. It is also important to know that medications do not work for everyone. We will discuss risks benefit and alternative including the option of not engaging in treatment. You also have the right to withdraw consent and terminate services at any time. You should understand that some medications require a taper to avoid discontinuation syndrome. Medications will require periodic reviews and may not be reordered without a follow up appointments.

Please determine who will be involved in your treatment including calling for appointments.

Name	Relationship	Phone:
	Parent	
	Primary care	
	Therapist	

My signature below indicates that I have read the above information and am requesting mental health treatment from Jolyn Zeller, PMHNP d.b.a. *Solarity Mental Health, PC*.

SIGNATURE:_____ DATE:_____

Client

SIGNATURE:_____ DATE: _____

Parents/guardians signature