HEALING MINDS

Psychiatric-Mental Health Nurse Practitioner

New Patient Registration & Demographics

Please complete this registration form before your first appointment.

Full Legal Name:

Preferred Name:

Date of Birth (MM/DD/YYYY):

Home Address:

City, State, ZIP:

Mobile Phone:

Email Address:

Emergency Contact

Name:

Relationship:

Phone Number:

Insurance Information (if applicable)

Insurance Carrier:

Member ID:

Group Number:

Policy Holder Name:

Preferred Pharmacy

Pharmacy Name:

Pharmacy City:

Referral Source

How did you hear about us?

Your signature confirms that the above information is accurate.

Signature (Typed Name):

Date:

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Consent for Treatment

Please review and complete this consent form before beginning psychiatric services.

I understand that treatment at Healing Minds may include psychiatric assessment, diagnosis, medication management, psychotherapy, or referrals as clinically appropriate.
I understand the risks, benefits, and alternatives to treatment and agree to participate voluntarily. I understand I may withdraw consent at any time, except in emergencies.

TELEHEALTH CONSENT:
If services occur by telehealth, I must physically be located in California during the session.
I understand the risks of technology issues and privacy limitations in telehealth visits.

EMERGENCY POLICY:
Healing Minds does not provide emergency services. For emergencies, I agree to call 911 or go to the nearest emergency room.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

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HIPAA Privacy Practices Acknowledgment

Please complete this required acknowledgment before your first appointment.

I acknowledge that I have received and reviewed the Healing Minds Privacy Policy & Notice of Privacy Practices (NPP). I understand how my Protected Health Information (PHI) may be used and disclosed as permitted by law.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

Your typed signature confirms receipt of the HIPAA Notice of Privacy Practices.

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HIPAA Consent for Treatment, Payment & Healthcare Operations (TPO)

This form authorizes Healing Minds to use and disclose your Protected Health Information (PHI) in accordance with HIPAA regulations for treatment, payment, and healthcare operations (TPO).

• TREATMENT:
Includes coordination of care, prescribing medications, consultation with other providers when necessary, and the use of PHI to provide clinical services.

• PAYMENT:
Includes billing insurance, verifying benefits, submitting claims, and communicating with your insurance plan to obtain payment for services.

• HEALTHCARE OPERATIONS:
Includes administrative tasks, quality improvement, recordkeeping, licensing, and other activities permitted under HIPAA to maintain efficient clinic operations.

• LIMITS OF DISCLOSURE:
PHI will only be disclosed according to HIPAA standards. Psychotherapy notes are NOT shared without a separate written authorization.

• RIGHT TO REVOKE:
You may revoke this consent in writing at any time, except to the extent that action has already been taken based on previous authorization.

• EMERGENCIES:
In case of a medical or psychiatric emergency, PHI may be disclosed to ensure your safety.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

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Telehealth Consent

Please review and complete this telehealth consent before engaging in remote sessions.

Telehealth involves the use of electronic communications to deliver health services.
I understand that telehealth may include audio, video, or other electronic communication.

LOCATION REQUIREMENT:
I agree that I must be physically located in the state of California during any telehealth session, and I will notify my provider immediately if I am located outside of California.

RISKS & LIMITATIONS:
I understand that telehealth may include risks, such as interruptions, unauthorized access, or technical difficulties. I understand that confidentiality cannot be guaranteed with technology.

BENEFITS:
Telehealth may provide increased access to care, convenience, and continuity of treatment.

EMERGENCY PROCEDURE:
I understand that telehealth sessions cannot be used for emergencies. If I am in crisis, I agree to call 911, go to the nearest emergency room, or call 988 (Suicide & Crisis Lifeline).

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

HEALING MINDS

Psychiatric-Mental Health Nurse Practitioner

Financial Policy & Payment Agreement

Please review the following financial policies carefully. Your signature indicates agreement to these terms while receiving services at Healing Minds.

- PAYMENT: Payment is due at the time of service unless prior arrangements have been made. You agree to keep a valid credit/debit card on file for copays, deductibles, or balances.

- INSURANCE: If using insurance, you authorize Healing Minds to bill your plan on your behalf. You understand you are responsible for any portion not covered by insurance.

- CANCELLATION POLICY: Appointments must be canceled or rescheduled at least 24 hours in advance. Late cancellations or no-show appointments may be charged a fee of $90.

- COMMUNICATION FEES: Non-clinical paperwork, letters, forms, or extended administrative time may incur additional fees, depending on complexity.

- REFUNDS: Refunds are not provided for rendered services.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

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Psychiatric-Mental Health Nurse Practitioner

Credit Card Authorization Form

I authorize Healing Minds to securely store my credit/debit card information and to charge my card for:
- No-show or late cancellation fees ($90)
- Copayments, deductibles, or any remaining balance not covered by insurance

I understand that my card information will be kept securely and may only be used for the purposes listed above.

Card Information

Cardholder Name:

Card Number (last 4 digits acceptable):

Expiration Date (MM/YY):

Billing ZIP Code:

Patient Information

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Your typed signature authorizes the use of your card according to the terms above.

Signature (Typed Name):

Date:

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Office Policies & Practice Agreement

Please review and acknowledge the following office policies to ensure clarity of care and expectations.

• COMMUNICATION POLICY:
Non-urgent messages will be returned within 48–72 business hours. Email/text should not be used for urgent concerns, emergencies, or crisis situations.

• PHONE & EMAIL USE:
Email is not HIPAA-secure. Limit email to scheduling needs only. No clinical advice will be provided by email or text.

• MEDICATION REFILLS:
Allow 3 business days for refill processing. No refills will be provided after hours, weekends, or holidays. You must attend appointments to receive medication refills.

• CONTROLLED SUBSTANCES:
Some medications require strict monitoring, urine drug screens, and regular follow-up visits.

• FEES FOR PAPERWORK:
Letters, forms, disability paperwork, and extended administrative work may incur additional fees depending on complexity and time involved.

• EMERGENCIES:
Healing Minds does not provide emergency services. For emergencies, call 911 or 988, or go to the nearest emergency room immediately.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

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Consent for Communication (Email, Text, Voicemail)

This form allows Healing Minds to contact you using email, text messages, and/or voicemail. These methods are not always HIPAA-secure. By signing below, you consent to non-secure communication for scheduling and basic administrative purposes only.

• PURPOSE OF COMMUNICATION:
Appointment reminders, scheduling updates, basic instructions, or follow-up needs.

• RISKS:
Email and text messaging may not be fully secure. There is some risk of interception or unauthorized access to your information.

• LIMITATIONS:
No clinical advice, diagnoses, or sensitive health information will be sent via text or email.
For emergencies, call 911 or 988 immediately.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Email Address:

Mobile Phone:

By signing below, I consent to be contacted by:

Email (Yes/No):

Text Messages (Yes/No):

Voicemail Messages (Yes/No):

Signature (Typed Name):

Date:

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Insurance Communication & Billing Authorization

This form authorizes Healing Minds to communicate with your insurance company regarding billing, eligibility, claims processing, and required clinical documentation for reimbursement purposes.

• PURPOSE OF DISCLOSURE:
To verify benefits, submit claims, process prior authorizations, or respond to insurance requests.

• INFORMATION THAT MAY BE DISCLOSED:
Diagnosis codes, treatment dates, service type, required documentation, and provider information.

• LIMITATIONS:
No psychotherapy session notes will be released. Only information required for billing or insurance operations will be disclosed.

• FINANCIAL RESPONSIBILITY:
I understand that I am financially responsible for all charges not covered or denied by insurance.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Insurance Company Name:

Member ID:

Signature (Typed Name):

Date:

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Safety Plan / Crisis Plan Agreement

This safety plan outlines steps the patient agrees to take during times of elevated distress or crisis.
This form is NOT for emergencies. Call 911 or 988 immediately if you are in danger.

Warning Signs (What indicates a crisis may be developing?):

Coping Strategies (What you can do to calm or help yourself):

Support System (Who you can contact for support):

Steps to Ensure Safety (Removing means, securing medications, etc.):

Signature (Typed Name):

Date:

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Medication Consent Form

This form explains the purpose, risks, benefits, and alternatives of psychiatric medications.
Please read carefully and ask any questions before signing this consent.

• PURPOSE OF MEDICATION:
Psychiatric medications are prescribed to treat symptoms such as anxiety, depression, mood instability, ADHD, sleep disturbances, and other mental health conditions.

• BENEFITS:
Many patients experience symptom improvement, increased stability, and improved daily function.

• RISKS & SIDE EFFECTS:
All medications have potential side effects. These may include changes in sleep, appetite, weight, energy, or mood. Rare but serious side effects may occur.

• PREGNANCY & BREASTFEEDING:
If you are pregnant, planning pregnancy, or breastfeeding, you must notify your provider immediately before continuing medication.

• INTERACTIONS:
Some medications interact with alcohol, cannabis, supplements, or other prescriptions. Always discuss new medications with your provider.

• FOLLOW-UP CARE:
Medications require regular follow-up appointments. Missing appointments may result in paused or discontinued prescriptions.

• ALTERNATIVES:
Alternatives may include therapy, lifestyle changes, or no treatment.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date:

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Controlled Substance / Stimulant Medication Agreement

This agreement is required for patients who are prescribed controlled substances, including but not limited to stimulant medications (e.g., Adderall, Vyvanse, Ritalin), benzodiazepines, or other medications that require monitoring under federal and state regulations.

• SAFE USE:
I agree to take medication exactly as prescribed. I will not change my dose without provider approval.

• NO EARLY REFILLS:
Early refills will NOT be provided for lost, stolen, or misplaced medications.

• PRESCRIPTION MONITORING:
I understand that my provider will check the CURES database to monitor controlled medication use.

• ONE PRESCRIBER RULE:
I agree to receive controlled medications only from Healing Minds unless otherwise approved.

• URINE DRUG SCREENS:
Random drug testing may be required to ensure safe and appropriate use.

• APPOINTMENT REQUIREMENTS:
I agree to attend scheduled follow-up appointments; missed visits may result in medication being paused.

• NO SHARING OR SELLING:
Misuse, sharing, or selling medication will result in discontinuation and possible reporting.

• EMERGENCIES:
For emergencies, I understand this office does not provide crisis services and I will call 911 or 988.

Full Legal Name:

Date of Birth (MM/DD/YYYY):

Signature (Typed Name):

Date: