



Thank you for choosing **Reliance Health Systems** for your healthcare needs. We are committed to serving our patients from our clinic located in Tri-Cities, Washington. This document provides you with an introduction to our practice, policies, as well as information pertaining to your privacy, patient rights, consents, and fees. If you have any questions, please feel free to ask during your consultation.

WHAT TO EXPECT:

If you are coming in for a psychiatric consult/care, you will initially talk with one of our therapists for an intake to discuss your concerns, ongoing symptoms, and past mental/behavioral health history. After your intake you will be scheduled with one of our psychiatric medical providers to further discuss your ongoing symptoms and construct a personalized treatment plan for further individual therapy, medication management, and/or other services for diagnostic screening and treatment. **NOTE: Please bring your current medication list and past medical records if available for your first visit. If you don't have them, you will be asked to sign a Release of Information for us to obtain copies of your previous medical/mental health records.**

Please read and complete the following information below in our New Patient Registration. You can return this to our office electronically through Patient Portal (MYIO) or by bringing in a physical copy to the NeuroPsych Program office. For all your visits to Reliance Health Systems, please bring your Picture ID and Insurance card for verification.

SERVICES WE OFFER:

NeuroPsych Program:

- Counseling/Therapy:
 - Individualized therapy sessions conducted onsite or through telehealth services
- Psychiatric Consultation and Care:
 - Individualized psychiatric consults conducted onsite or through telehealth services
 - Medication Management

Brain Stim at Reliance Health Systems:

- Repetitive Transcranial Magnetic Stimulation
 - FDA Cleared for Adults with Major Depressive Disorder, Treatment Resistant Depression, Anxious Depression, and/or Obsessive-Compulsive-Disorder
 - FDA Cleared for Adolescents with Major Depressive Disorder
- SPRAVATO® (esketamine)
 - FDA approved for Adults with Treatment Resistant Depression
- Qb Check ADHD testing/evaluation
- EKG testing and interpretation services

Residential Treatment Facility a Division of Reliance Health Systems - Coming Soon



NOTICE OF PRIVACY PRACTICES

This notice summarizes how Reliance Health systems may use or disclose your medical information and your rights provided under the new Health Insurance Portability and Accountability Act (HIPAA). This form may not be all inclusive of all situations. We are required to give you notice of our privacy practices stating how and what we can and cannot use and disclose regarding your health information that you have given to use or that we have learned about you when you were a patient at our clinic.

You have the right to:

- Obtain a copy of the Notice of Privacy Practices upon request. This document explains your privacy rights and how your information may be used by Reliance Health Systems.
- Request a restriction on certain uses and disclosures of your information. We are not required by law to agree to your request in certain situations. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
- Inspect and request a copy of your health record. We may deny your request under very limited circumstances. If you are denied access to health care information, you may request that the denial be reviewed by another health care professional chosen by someone on our health care team. We will abide by the outcome of that review. There is a fee for this service.
- Request an amendment to your health record. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. Also, we may deny your request if the information was not created by our health care team, not part of the information kept by our facility, not part of the information which you would be permitted to inspect and copy, and if the information is not accurate and complete. Please note that even if we accept your request, we are not required to delete any information from your health care record.
- Obtain an accounting of disclosures of your health information. Accounting will only provide information about disclosures made for purposes other than treatment, payment, or health care.
- Request communication of your health information by alternative means or locations. Your request must be in writing, and Reliance Health Systems may deny your request if it is not practical.
- Provide the hospital with a signed authorization. This document will be used to disclose your health care information other than reasons besides treatment and payment.
- Revoke your authorization. You may request in writing to revoke your authorization to use or disclose health care information except to the extent that action has already been taken.
- File complaints about any aspect of our health care information practices to use or the Department of Health and Human Services or the United States. You can file a complaint with us and expect an investigation and explanation by calling or writing to: Reliance Health Systems, 1446 Spaulding Ave, Ste 303, Richland, WA 99352. You can file a complaint to the Dept. of Health and Human Services by addressing your written complaint to: Secretary, Department of Health, and Human Services.

Reliance Health System's Obligations to you are:

- To provide written notice of how Reliance Health Systems uses and discloses your health care information as explained in this form. Your health care information will not be used for marketing activities.
- Only the minimum necessary information will be used and disclosed except for treatment activities.
- To protect your health care information with Business Associates. Reliance Health Systems will have written agreements with healthcare vendors and suppliers who require your health information.
- To use and disclose your protected healthcare information for treatment, payment, hospital, and to satisfy state, federal, law enforcement, and oversight reporting requirements.



TREATMENT AGREEMENT AND CLINIC POLICIES

CONSENT FOR TREATMENT: The undersigned hereby consents to treatment and services that may be rendered, as ordered by a healthcare professional. I understand that my care is under the control of my attending providers, his or her assistants, and/or designated personnel, and that Reliance Health Systems (RHS) is not liable for any act or omission of treatment when following the instructions of that provider.

APPOINTMENT POLICY: You are requested to arrive **15 minutes prior** to your scheduled time to check in and fill out any required paperwork. If you are running late or have a change in your schedule, please let our office know as soon as possible. If you arrive **10 minutes late** for an appointment this will result in a **cancellation**, and we will have to reschedule your appointment. **Same day cancellations or no-shows for appointments will result in a \$50 no-show fee which will be added to your balance.** If you have **three no-shows (not showing up for appointments) and/or same day cancellations/reschedules in a 3-month period, you will be discharged from our practice.** Written notice will be mailed to the address on file.

To provide you with high quality health care it is important for you to keep your scheduled appointment with your provider. Valuable time has been reserved for you or your family member. A missed, late, or cancelled appointment results in lost time which could have been given to another person waiting to receive care. **Every day we get many calls for appointments from both old and new patients. By canceling your appointment as soon as possible, we can help other patients who are waiting to be seen.**

For continuation of care a patient needs to be seen a **minimum once every 6 months**, noncompliance will result in a discharge. You will receive a phone call and/or letter mailed informing you that RHS is discharging you from its services. If you wish to resume treatment after being discharged, eligibility to restart the intake process will be determined on a case by case basis. In some circumstances **monthly visits** are required, in cases of Scheduled/Controlled Medication refills.

RESPONSIBLE PARTY INFORMATION: If someone else is responsible for your health insurance or if the patient is a minor, RHS will need their name, relationship to patient, and date of birth of the patient's guarantor/responsible party. To avoid any delays or inaccuracies please ensure the necessary insurance information is accurately filled out. It is your responsibility, as the patient, to report any changes in insurance before appointments.

MEDICARE PATIENTS WITH SECONDARY INSURANCE: Patients with Medicare Part B, secondary insurance (ex. Medicare Advantage plans), and/or tertiary insurance (ex. State Medicaid) are responsible to fill out all the appropriate information below. Please provide all appropriate documentation such as insurance cards to our patient care coordinator to appropriate assign in your chart to avoid any billing delays or inaccuracies.

FINANCIAL POLICY: I hereby assign and authorize payment directly to RHS for all hospital and medical insurance benefits otherwise payable to me, in an amount not to exceed the clinic's charges for its services. I understand I am financially responsible to RHS for any charges unpaid under this assignment, including but not limited to co-pay, co-insurance, and/or deductibles. Should legal action become necessary to collect this bill, I understand I will be held responsible for collection expenses. To prevent any misunderstandings about our fees and your medical insurance, please be aware that:

- You are liable –**not your insurance company**– for the bill and any uncovered portion of our fees. You will receive a separate bill from the lab that analyzes services rendered such as pap smears, cultures, and any biopsies performed (this list is not all-inclusive).
- Any balance on your account is your responsibility. Your monthly statement reflects your previous balance, new charges, payments or credits.
- Check with your insurance company regarding preferred provider status before your appointment to avoid an increase in out-of-pocket expense.



- **Co-pays and all self-pay fees are due at the time of services. A list of self-pay rates is available upon phone call to RHS.**
- A **\$35 fee** will be issued on all returned checks.
- A **\$50 cancellation fee** will be issued for any patients who don't show or cancel their appointments on the same day.
- **Administrative Copying Fees:** There is an administrative copying/printing fee per page printed. If files are extensive/long, patients can provide us with a USB for a digital copy of their records for a one-time clerical fee. If the provider personally edits confidential information from the record, as required by statute, the provider can charge the usual fee for basic office visits. Rate for clerical fee, pages 0-30, and pages 31+ are set to reflect current WAC 246-08-400 standards.

COMMUNICATION POLICY: RHS provides reminder/follow-up calls as well as email/text/phone call reminders for in-person and TeleHealth visits/appointments. Due to the nature of these correspondence we may need to leave a message with an individual and/or answering machine. If you wish to stop automated texts or phone calls, please let your patient care coordinator know. PLEASE NOTE: Due to health care privacy laws, any email or other social media communication will not be used to send/respond with information regarding appointments, diagnoses, prescription requests, and/or any other health care related information. You will still need to call our office for those services.

CO-PARTICIPATION OF CARE POLICY: Due to the sensitive nature of Mental Health Information and your HIPAA rights, clinic staff are not allowed to disclose your information or disclose that you are patient at our practice unless specifically authorized. If you wish to have other individuals communicating on your behalf or would like to have additional party's privy to your health care information, please complete an Authorization for Co-Participation of Care. Information you can authorize to be shared includes but is not limited to healthcare, appointment, diagnostic, billing, and/or insurance information. If you have filled out this form as a minor and continue services into adulthood, you will be asked to fill out a new form if you wish to continue allowing others to participate in your care. If you want to revoke your current co-participation of care agreement, please contact RHS verbally or in writing to notify us of this change. If you have a Power of Attorney or another legal representative who makes medical decisions for you, please provide our clinic with the legal documents indicating this.

AGGRESSIVE BEHAVIOR POLICY: Aggressive and violent behavior towards staff and other patients will not be tolerated at RHS. This includes but is not limited to verbally abusive language, verbal threats, intimidating physical behavior, violent behavior that comprises of intentional uses of physical force, power, threatened or actual against self, another person (patients, staff, etc.), clinic properties, etc. Initial assessment of a patient who is being aggressive may be subject to formal verbal warning from management or other designated clinic staff. If there is continuation of behavior or escalation of behavior, patients may be subject to removal from property by clinic staff or police authority and subject to formal written warning regarding their behavior. If despite issuing formal verbal and written warnings, the patient continues to have repeated or persistent exhibition of aggressive and/or violent behaviors, the patient may be discharged from practice and/or excluded from the premises indefinitely. An incident report will be filed at the clinic level at each altercation.

MEDICATION POLICY: Patients should call their designated pharmacy first to request any medication refills. You can also call our office for a prescription refill request between Monday-Thursday during clinic hours **ONLY** (9:00 am to 5:00 pm). We are authorized to take up to **3 business days** to process prescription(s) renewal and/or pick-up requests. You are responsible, as the patient, for knowing when your medication(s) will need to be refilled (no early refills). Certain medications require prior authorization to be prescribed, this process can take up to 1-3 days pending approval from your insurance company. No prescriptions will be refilled, or prior authorizations processed on Saturdays, Sundays, or Holidays. In addition, prescriptions will not be filled for unauthorized "walk-in" patients. Please note:

- Prescriptions will be verified through the Washington State Prescription Monitoring Program (PMP).
- Non-controlled/non-narcotic prescriptions require a follow up appointment every **3-6 months**.



- Controlled substance prescription requires a follow up appointment every **30-60 days**.
- New symptoms and/or events require a clinic appointment. Your provider is unable to diagnose via phone message or email.
- Do not use any non-prescribed substances such as **marijuana and/or illegal substances** while taking your prescribed medications, doing so may cause adverse interactions that are detrimental to your health.
- There will be no early refills if medications are overused/abused/misused. You must follow prescription directions.
- Your prescription will not be replaced if lost, stolen, misplaced, overused, etc.
- Medications are for the prescribed individual's use only. It is illegal to **share** your medication.

CONTROLLED SUBSTANCES TREATMENT CONSENT: Medications such as opioids (ex. narcotic and analgesics), benzodiazepine (ex. Xanax, Ativan, Klonopin, and Valium), barbiturate sedatives, and muscle relaxants (ex. Cyclobenzaprine), ADHD Stimulant medication (ex. Adderall, Ritalin, Vyvanse etc.) are considered state and federally regulated **controlled substances**. The long-term use of these drugs is controversial because patients carry the risk of developing physical and/or psychological dependence. Other side effects include but are not limited to drug interactions, sedation, unsteadiness/trembling, increased risk of falls, and memory problems. To ensure the safety of our patients, these substances must be tightly regulated. It is our professional medical opinion at RHS to increase accountability and limit the usage of controlled substances. **For you as a patient, this means any previous prescription of a controlled substance may not be continued at your initial visit with our Providers.** All controlled substances will be verified through the Washington State PMP and afterward a proper treatment plan will be made for you. As recommended by the FDA, we do not prescribe benzodiazepines to patients who are taking other controlled substances for pain as their combined use could result in serious side effects including slowed and difficult breathing and/or death. If needed we will gladly provide you with information about preferred alternative treatments such mental health therapies, other medications, and/or referral services to address dependence on controlled substances.

ATTENTION DEFICIT AND HYPERACTIVITY DISORDER POLICY: It is RHS clinic policy to uphold the highest level of healthcare for our new and pre-existing patients with Attention Deficit and Hyperactivity Disorder (ADHD). ADHD is a neuropsychiatric condition which affects patients of all ages. It is a complex diagnosis and said diagnosis should not be made lightly. Our clinic provides thorough ADHD examinations which include subjective and objective evaluations to assess, diagnose, and treat patients with ADHD. This includes but is not limited to initial intake with a therapist, establishing care with psychiatric medical provider, subjective interview with patient, extensive medical records review, initial objective diagnostics (QbCheck and EKG), vitals, regular prescription monitoring program (PMP) report review, monthly-bimonthly in-office visits, and therapeutic diagnostics (repeat QbCheck and EKG) to determine treatment efficacy. If patients are not compliant with treatments and do not complete all the required evaluations as listed above, RHS's psychiatric medical providers may not start or continue ADHD medication treatment to ensure continued safety for the patients undergoing ADHD treatment.

Since October 2022, there has been an ADHD stimulant medication (ex. Adderall, Ritalin, Concerta, Vyvanse, etc.) shortage nationwide. Due to this, in the future if prescribed any of these medications, patients may have to call their pharmacy or other in-network pharmacies ahead of time to see if they have their prescription in stock. Given that these medications are Schedule II Controlled substances, only one-month prescriptions are allowed at a time without refills. Our providers will not send multiples of the same prescription at one time to different pharmacies. In addition, it is our clinic policy to only send these prescriptions to one other additional pharmacy after cancelling the first prescription if there isn't sufficient stock. Early prescriptions are only allowed in limited extenuating circumstances. If you received a partial prescription from the pharmacy due to stock issues, it will be up to the individual provider to approve sending an additional prescription. If your prescription is lost or stolen patient must file a police report and supply this to our clinic before an additional prescription can be written.



RELIANCE
Health Systems

Reliance Health Systems

Phone: (509) 420-5060

Fax: (509) 420-5059

Address: 1446 Spaulding Ave, Ste 303
Richland, WA 99352

Email: contact@rhs.health

Website: <https://rhs.health/>

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES, TREATMENT CONSENT, AND CLINIC POLICIES

By signing below, I hereby acknowledge receipt of the Reliance Health System's Notice of Privacy Practices.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

By signing this form, I ensure Reliance Health Systems I have read, understood, and accepted all the terms listed above in the treatment consent and clinic policies.

Signature: _____ **Date:** _____

Printed Name: _____ **Relationship to Patient:** _____

If you would like a copy of our Notice of Privacy Practices, Treatment Consent, and/or Clinic Policies for your personal record, please ask one of our patient care coordinators/receptionists and they will gladly provide you with a copy.



DEMOGRAPHIC INFORMATION *(please show your photo ID to the receptionist)*

Patient Name: _____

Preferred Name: _____ Date of Birth: _____ Social Security #: _____

Sex at birth: Female Male Gender Identity: _____ Preferred Pronouns: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Marital Status: Single Married Divorced Separated Widowed Partnered Other

Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address/ P. O. Box: _____

Email: _____ Cell Phone: _____ Home Phone: _____

EMERGENCY CONTACT INFORMATION

Contact Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Contact Name: _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip Code: _____

BILLING AND INSURANCE INFORMATION *(please show your insurance card to the receptionist)*

I would like to receive Billing Statements Through: Patient Portal Secure Email Postal Mail

Primary Insurance: _____

Secondary Insurance: _____

Policy #: _____

Policy #: _____

Group ID #: _____

Group ID #: _____

Name of Policy Holder: _____

Name of Policy Holder: _____

Relation to Patient: Self Spouse Parent

Relation to Patient: Self Spouse Parent

Policy holder's DOB: _____

Policy holder's DOB: _____

Policy holder's SSN: _____

Policy holder's SSN: _____

Policy Holder's Employer: _____

Policy Holder's Employer: _____



Reliance Health Systems

Authorization of Co-Participation of Care

Patient Name: _____ **DOB:** _____

I authorize Reliance Health Systems to share information regarding my health care with the following people (leave blank if there is nobody you wish to participate in your care). If I want to revoke my co-participation of care with any of the below people I will contact Reliance Health Systems verbally or in writing to notify them of this change.

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

Please select the information you authorize to be shared with the people you have listed (*Check all that apply*):

- | | |
|--|--|
| <input type="checkbox"/> Healthcare information | <input type="checkbox"/> Appointment Information |
| <input type="checkbox"/> Laboratory Results | <input type="checkbox"/> Account Information (Billing) |
| <input type="checkbox"/> Radiology and Imaging Reports (X-Ray, MRI, CT Scan, etc.) | <input type="checkbox"/> Insurance/Reimbursement |
| <input type="checkbox"/> Other: _____ | |

Your signature below indicated your agreement to the above policy and all of the conditions herein.

Patient Signature: _____ **Date:** _____