Beckman Center

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Our goal with this handout is to provide you with information that we will need, a brief description of why and what you can expect at your next appointment.

You will receive orientation on how we bill for our services and sign various forms that are required in order for you to receive our services.

You will need to bring with you at your next appointment the following items:

1. Social Security Card
2. Medicare, Medicaid, and/or Insurance cards.
3. Picture ID (Example: driver's license, school id, wallet photo)

You will be asked to sign the following consent forms:

1. Permission to Follow-up
2. Orientation
3. Voter Registration
4. HIPPA Consent
5. Consent to Examine and Treat
6. Family Member Designation
7. Prescription Pick Up

PERMISSION TO FOLLOW UP

This form includes your contact information. This form will be sent to our administration office in order for them to contact you to participate in a short telephone survey. This survey will provide valuable information on the services we provide, the treatment you received and your experience with our staff.

ORIENTATION

You will be given a booklet entitled "Spotlight". It contains our mission statement, your rights as a patient, what you can expect from us, and how we bill. It also contains contact information on all of our locations.

VOTER REGISTRATION

If you are currently not registered to vote, or if you have a family member who would like to register to vote, we can provide you with the necessary forms to achieve this privilege. Your therapist can assist you in completing the form if you need assistance.

HIPAA

You will receive a pamphlet that explains your rights concerning the information we collect from you and maintain in your record. You receive this same documentation at any medical or dental office.

CONSENT TO EXAMINE AND TREAT

This consent form allows a therapist to talk with you, the nurse to monitor or administer medications you receive from a clinic or school. Weight and vitals are obtained at the clinic, which allows the doctor to examine your progress and stability, as well as providing Tele-psychiatry services.

FAMILY MEMBER DESIGNATION

You will be given an opportunity to designate a family member or another individual with whom we may discuss your condition with.

PRESCRIPTION PICK UP

The physician may leave sample medications or prescriptions for the medications we prescribe for you to pick up from the clinic. You will have the option to designate someone to pick these items up for you in the event you are not able to obtain them yourself.

We hope that this information has been helpful to you and we look forward to seeing you again.

CMHC BILLING REFERENCE LIST - July 1, 2018

SERVICE CODE	SERVICE DESCRIPTION AND ABBREVIATION	FREQUENCY/ TIME SPAN	SCDMH SERVICE CHARGE
H001-0	Crisis Intervention Service (CI)	**20** / 15 mins Units day	$50.00
H001-T	Crisis Intervention Service via telephone (CI)Non Physician	**4** / 15 min units day	$50.00
H002	MH Assessment by Non Physician (ASSMT)	**8** / 30 min units day	$89.00
H003	Individual Therapy (IND TX)	**1** / Encounter day	$88.00 $175.00 $265.00
H004-001	Family Therapy, client present (FM TX)	**1** /Encounter day	$264.00
H004-002	Family Therapy, client not present (FM TX)	**1** / Encounter day	$263.00
H005-GTX	Group Therapy (GP TX)	**2** / Encounter day	$84.00
H005-MFG	Multi Family Group Therapy (MFT)	**8** / Encounters month	$84.00
H010	Injectable Medication Administration (MED. ADM.)	See Table	See Table
H012	Psychiatric Diagnostic Evaluation with Medical (PDE) 1st PDE by MD	**1** / Encounter day then **1** / Encounter 6 mos.	$601.00 (00) $657.00 (HA) $661.00 (GT)
H013	Psychiatric Diagnostic Evaluation with Medical - Advanced Practice Registered Nurse (PDE - APRN) 1st PDE by APRN	**1** / Encounter day then **1** / Encounter 6 mos.	$330.00
H014	Behavioral Health Screening Alcohol/Drug (BHS)	**2** / 15 units day	$44.00
H016	Injection Administration (INJ.ADM)	**40** / 15 units month	$25.00
H017	MH Service Plan Development by Non Physician (SPD)	**12** / 15 min units day	$44.00
H017-T	MH Service Plan Development by Non-Physician via telephone (SPD)		
H021-0	Nursing Services (NS)	**7** / 15 min units day	$48.00
H021-M	Nursing Services Medication Monitoring (NS)	**7** / 15 min units day	
H021-T	Nursing Service via telephone (NS)	**2** / 15 min units day	
H031	Targeted Case Management - In-Field (TCM)	**16** / 15 min units day	$42.00
H032	Targeted Case Management - In-CMHC (TCM)	**16** / 15 min units day	$42.00
H052	Medical Evaluation and Management for Established Patient/Subsequent PDE (MD)	**1** / Encounter day	$125.00 (00)
			$133.00 (GT)
			$247.00 (00)
			$265.00 (GT)
			$394.00 (00)
			$397.00 (GT)
H053	Medical Evaluation and Management for Established Patient/Subsequent PDE (APRN)	**1** / Encounter day	$66.00 $132.00 $195.00
H056	Psychosocial Rehabilitation Services PRS	**24** / 15 min units day	$26.00 RN (OTD) $11.00 MHP (OHO) $10.00 BA (OHN) $ 10.00 LPN (OTE)
H057	Family Support - **Children Only**	**32** / 15 min units day	$48.00 RN (OTD) $45.00 MHP (OHO) $40.00 BA (OHN)
H058	Behavior Modification - **Children Only**	**32** / 15 min units day	$45.00 MHP (OHO) $40.00 BA (OHN)
H059	Peer Support Services	**16** / 15min units day	$15.00 ≤ BA (OHM)
H060-001	Service Plan Development Interdisciplinary Team With Client (SPDIT)	**1** / Encounter (unit) day up to **6** / Encounters 12 mos.	$88.00
H060-002	Service Plan Development Interdisciplinary Team Without Client (SPDIT-NC)	**1** / Encounter (unit) day up to **6** / Encounters 12 mos.	$87.00

NEW PATIENT INFORMATION

INFORMATION ABOUT THE PATIENT (please complete all fields)

Last Name:_____ **First Name**_____ **MI** _____

Residence Street Address: _____

City State Zip: _____

Mailing Address: _____

City State Zip:_____

Home Phone #:_____ **Cell/Work #**: _____

Email Address: _____

Social Security Number: _____ **Date of Birth**: _____

Race: __ American Indian/Alaska Native __Asian __Black/African American __More than one Race __White

Ethnicity: __Cuban __Mexican/Mexican American __Not Hispanic __ Puerto Rican

Sex: Male __ Female: ___ **Marital Status**: __Single __Married __Divorced __Widowed __Separated

How many people live in household: _____ **How many children does the patient have**: _____

Current/Highest level of Education: _____ **School Attending**:_____

Religion: _____ **Registered to Vote**: ___Yes ___No

Please indicate areas in which you may require accommodations:

____Hearing ____Speech ____Vision ____Walking ___Language: Preference: _____

Are you a Veteran: _____ Branch of Service: _____

EMERGENCY CONTACT PERSON / NEXT OF KIN

Last Name:_____ **First Name**:_____

Address:_____ **City, ST, Zip**_____

Relationship to patient: _____ **Phone:** _____

FINANCIAL INFORMATION (Person responsible for the bill if Insurance/Medicare/Medicaid does not pay?)

Last Name: _____ **First Name**: _____

Social Security Number: _____

Address: _____**City, State, Zip**:_____

Relationship to Patient: _____

Phone Numbers: Home _____ **Cell** _____

THIRD PARY BILLING (Insurance, Medicaid, Medicare)

Insurance Company Name: _____

Insured's Name: _____ **Place of Employment**: _____

Relationship to patient: _____ **Insured's Date of Birth**: _____

Medicaid Number: _____

Medicare Number: _____