☐ CheckBox1

EMERALD COAST MOOD & MEMORY, P.A.
922 Mar Walt Drive, Suite 100
850-226-4785 Phone 850-226-4786 Fax

Welcome To Our Practice!

Welcome

You, the patient, are the most important person in our office. We are committed to providing you with the best possible medical care. Excellence is our goal. We have worked to provide a full range of services and have highly trained and knowledgeable staff.
Please do not hesitate to ask us any questions.

Office Hours

Phones: Telephones are answered 8 a.m. – 12:00 p.m. and 1:30 p.m. – 5 p.m. Monday – Friday.
Office Hours: Office hours are Monday – Friday 8 a.m. – 5 p.m. We are closed most major holidays.
Emergencies: For life-threatening situations, call 911. If you have an urgent problem after office hours, please call 863-7682.

Appointments

For appointments, please call 850-226-4785.

- Please call in advance for routine office visits. Make follow-up appointments as you leave. We make every effort to stay on schedule, although emergencies arise. If we are seriously delayed, we attempt to notify patients beforehand.
- As a courtesy to other patients and staff, please call the office as soon as possible if you are unable to keep your appointment or are going to be late.
- A "no show" charge of $50.00 will be billed for all appointments not canceled within 24 hours prior to appointment time. A patient with two "no shows" will be subject to the office disengagement policy.

Financial Policy

- Unless arrangements have been made in advance, co-payments, co-insurance, and any outstanding balances are expected at the time of service. Patients may be financially responsible for payment of all services even if their insurance company does not pay. Patient accounts not paid promptly are subject to third party collections and/or legal procedures.
- If we are not a participating provider with your plan, we will provide you with a receipt for you to file with your insurance company.
- Any check returned from the bank will result in an additional $30.00 charge that will appear on your account.
- If your insurance carrier has not responded to a claim within 90 days, we reserve the right to formally transfer all associated liability for the claim to the patient/guarantor. Failure to promptly resolve this balance may result in third party collection and or legal procedures to be taken. Please keep a close watch for carrier claim payment and contact the insurance carrier or our business office in the event a claim is not resolved within 60 days from the date of service.
- We realize that emergencies do arise that may affect timely payment of your account. If such extreme cases do occur, please contact our business office at 226-4785, extension 103.
- **Please always notify our office of any change in name, address, phone or insurance information**.

Prescription Policy

- Prescriptions and refills are written at the time of your appointment. Due to the importance of the medications and the possible side effects, it is necessary for Dr. Igleburger to review your medications with you. Any prescriptions or medications that are lost will not be refilled until the next scheduled appointment.
- Patients who cancel or no show for appointments and then need refills of medications will be charged $15.00 per prescription payable ***before*** the prescription is written or called in. Patients who cancel two appointments or more and require prescriptions to be filled will be subject to our disengagement policy.

Insurance

- ***Prior to your appointment***, please check your insurance information so you will be informed about pre-authorization, referrals, co-payments, and any deductible required at the time of the visit.
- **If your insurance company requires pre-authorization for your visit, it is your responsibility to get pre-authorized**. If your insurance company does not pay for your visit because pre-authorization was not approved, you will be responsible for the entire cost of the visit.
- For your first visit, please bring your insurance card and arrive 20 – 30 minutes early to complete the necessary patient information forms.
- We accept Medicare as well as some other insurers, however, please review all insurance information with our staff prior to services being rendered.
- Your health insurance contract is between you and your insurance company. Any complaints regarding your coverage should be directed to your carrier.
- Referrals: **Please allow 48 hours for referral processing**.
- Request: **Please allow 48 hours** for any request for records, faxed notes, etc.

What Do We Need From You?

- To inform the Medical Practice staff of any pertinent changes in insurance, employment, demographic information or relationships with other care/service givers.
- To arrive on time for scheduled appointments and cancel, when necessary, with a phone call 24 hours in advance of appointment or be subject to a "no show" charge of $50.00. Patients who miss two appointments may be disengaged from the practice.
- To provide payment for services requested and delivered by the Medical Practice not covered by insurance within 90 days.
- To notify the Medical Practice of any change in your health status.
- To follow the recommended treatment plan and inform the Medical Practice of any physical or mental impairment requiring special accommodation.
- To ask questions if directions and procedures are not understood.
- Trust and honesty between patients and this office is extremely important to us. Prescription abuse and/or non-compliance with medications also suicide attempts and/or medication overdoses show a lack of trust and confidence in the ability of Dr. Igleburger to handle your medical needs and you will be subject to immediate disengagement.
- At the discretion of this practice, Suicide attempts will result in immediate disengagement.

What Should You Expect From Us?

- To be treated with respect, dignity and be informed of your care needs to make appropriate decisions.
- Help plan your care and make changes to it.
- Expect that teaching materials will be provided in a manner you can understand.
- To be informed of the Medical Practice billing process.
- To have your records kept confidential except when consent has been given.
- To expect services to be professional, timely and appropriate.
- To communicate your complaints to the Medical Practice Manager and expect to receive follow-up without negative repercussions or changes in service.
- To receive care without discrimination due to race, religion, age, sex, disability or ethnic origin.

About Our Physician:

Prior to starting ECM&M in Fort Walton Beach, Florida, Dr. Igleburger worked for several years as the Medical Director of a large community mental health center in Western Kentucky. He then served as the Executive Medical Director of a dedicated and nationally recognized clinical trials facility, and the Associate Medical Director of the Behavioral Health unit at Lourdes Hospital, also in Western Kentucky. He has been a Principle Investigator and Sub-Investigator in numerous clinical trials involving many therapeutic areas.

Our Medical Director and CEO, Dr. James Igleburger is a Board Certified general adult psychiatrist with extensive experience in clinical psychiatry as well as clinical research. He earned his M.D. from the Medical University of South Carolina and completed residency at Akron general Medical Center in Akron Ohio.

I have read and understand the policies of this office. By signing below, I am agreeing to the terms set forth in this document.

______________________________________ _______________

Signature Date

NEW PATIENT INFORMATION SHEET

Name (Last) ________________________ (First) ________________________ (Middle) ____________________

Address ____

City _____________________________________ State ________________ Zip ___________________________

Home Phone ______________________________ Work Phone ____

Date of Birth _____________________Age _______ Social Security # ___________________________________

Marital Status (circle one) Single Married Widowed Divorced Separated

Name of Spouse ___________________________ **Who referred you?** ___________________________________

Name of Emergency Contact ______________________________ Phone ( ) ____________________________

Reason for Visit ____

Is your injury work related? (circle one) Yes No Employer ____________________________________

List all medications you are allergic to or state "none." ____
____

Have you ever been diagnosed or do you think you have Hepatitis? Y N What Type? _____ When? _____
Who Diagnosed You? ______

Name of your Physician _________________________Address ____

Pharmacy Name ____ Phone __________________________________

Primary Insurance Information

Ins. Co _______________________ Policy # ________________Group # ______________Phone _____________

Copay ________________________ Co Ins. % ______________ Address _________________________________

City ______________________________State ______ Zip ____________ Guarantor _________________________

Relationship ____________________ Employer ______________________ SSN _______________ DOB _______

Secondary Insurance Information

Ins. Co _______________________ Policy # ________________Group # ______________Phone _____________

Copay ________________________ Co Ins. % ______________ Address _________________________________

City ______________________________State ______ Zip ____________ Guarantor _________________________

Relationship ____________________ Employer ______________________ SSN _______________ DOB _______

Does your insurance require pre-authorization for your visit today? (Circle One) Yes No

I hereby authorize payment directly to the business office of Emerald Coast Mood and Memory, PA and Dr. James L. Igleburger, MD for psychiatric and/or medical benefits, if any, otherwise payable to me for service. I understand that I am financially responsible for the charges not covered by my insurance.

SIGNED (Parent of patient, if minor) ____Date ________________

EMERALD COAST MOOD & MEMORY, PA
DR. JAMES L. IGLEBURGER

Please list below, <u>ALL</u> medications you are *<u>currently</u>* taking (include dosage and when taken):

Please list any of the medications on the list below that you have taken in the past but are *<u>No Longer Taking</u>*.

<u>These are some commonly used medications.</u>

Adalat, Procardia
Adapin, Sinequan
Adderall, Dexedrin
Akineton
(Alprazolam)
(Amantadine)
Ambien
(Amitriptyline)
(Amoxapine)
Anafranil
Antabuse
Aricept
(Atenolol)
Atarax, Vistaril
Ativan
Aurorix
Axocet, Butisol
Bellergal, Donnatal
Benadryl
(Benztropine)
(Bromocriptine)
(Bupropion)
(Buspirone)
(Carbamazepine)
Cardizem
Catapres
Celebrex
Celexa
Centrax
(Chloral Hydrate)
(Chlordiazepoxide)
(Chlorpromazine)

(Clidinium Bromide)
(Clonazepam)
Clozaril
(Clorazepate)
Compazine
Corgard, Corzide
Cylert
(Cyproheptadine)
Cytomel, Triostat
Dalmane
Dantrium
Depakote, Depakene
(Nifedipine)
(Doxepin)
(Dextroamphetam)
(Biperiden)
Xanax
Symmetrel
(Zolpidem)
Elavil, Endep
Ascendin
(Clomipramine)
(Disulfiram)
(Donepezil)
Tenormin
(Hydroxyzine)
(Lorazepam)
(Moclobemide)
(Butabarbital)
(Phenobarbital)
(Diphenhydramin)
Cogentin

Parlodel
Wellbutrin
Buspar
Carbitrol, Tegretol
(Diltiazem)
(Clonidine)
(Celecoxib)
(Citalopram)
(Prazepam)
Librium, Libritabs
Thorazine
Librax, Quarzan
Klonopin
(Clozapin)
Tranxene
(Prochlorperzaine)
(Nadolol)
(Pemoline)
Periactin
(Lithyronine)
(Flurazepam)
(Dantrolene)
(Valproic Acid)
(Desipramine)
Desyrel
(Dexfenfluramine)
(Diazepam)
Dolophine
Dopor, Sinemet
(Droperidol)
Effexor
Eskalith, Lithobid

(Estazolam)
Etrafon, Triavil
(Fenfluramine)
(Flumzaenil)
(Fluoxetine)
(Fluphenzaine)
(Fluvoxamine)
(Gabapentin)
(Halazepam)
Halcion
Haldol
(Imipramine)
Imitrex
Inderal
(Levothyroxine)
Loratab, Loracet
Lopressor
(Loxapine)
Ludiomil
Mebaral
Mellaril
(Mesoridazine)
(Methylphenidate)
(Midazolam)
(Mirtazapin, Organon)
Moban
(Naltrexone)
Nardil
Navane
(Nefazodone)
Norflex
(Nortriptyline)

(Olanzapine)
(Oxazepam)
(Paroxetine)
(Paxipam)
((Protriptyline)
(Quetiapine)
Restoril
Risperdal
(Setraline)
(Sidenafilcitrate)
Surmontil
Norpramin
(trazodone)
Redux
Valium
(Methadone)
(L-Dopa, Levodopa)
Inapsine
(Venlafaxine)
(Lithium)
Prosom
(Perphenazine)
Pondimin
Romazicon
Prozac
Prolixin
Luvox
Neurontin
Paxipam
(Tirazolam)
Haloperidol)
Tofranil

(Sumatriptan)
(Propranolol)
Synthroid, Thyrar
(Metoprolol)
Loxitane
(Maprotiline)
(Mephobarbital)
(Thioridazine)
Serentil
Ritalin
Versed
Remeron
(Molindone)
Trexene
(Phenelzine)
(Thiothixene)
Serzone
(Orphenadrin)
Pamelor
Zyprexa
Serax
Paxil
Halazepam
Vivactil
Seroquel
(Temazepam)
(Resperidone)
Zoloft
Viagra
(Trimipramine)

EMERALD COAST MOOD & MEMORY P. A.
James L. Igleburger, M.D.

Patient Last Name		First	Middle	Parent or Guardian
Date of Birth	Sex	Social Security Number, Patient		Social Security Number, Guardian
Home Address, City, State, Zip		Home Phone Number		Work Phone Number
Local Address, City, State, Zip		Local Phone Number		Employer
Patient Number		Chart Number		Marital Status: married single divorced widowed separated

AUTHORIZATION and AGREEMENT for TREATMENT

The undersigned hereby makes the following Acknowledgments and Agreements regarding the treatment to be provided the person whose name appears on top hereof:

1) **CONSENT TO TREATMENT**: I understand medical treatment is necessary for the patient and that such medical care, treatment, and procedures will be performed by Dr. James L. Igleburger, M.D. and by employees of Emerald Coast Mood & Memory P. A. during its scheduled hours of operation. I hereby grant my authorization and consent to such treatment and procedures, and do certify that no guarantee or assurance has been made as to the results which may be obtained.

2) **AGREEMENT TO PAY FOR SERVICES**: For and in consideration of the care and treatment provided to the patient, I promise to pay Emerald Coast Mood & Memory, P.A. all charges for service rendered to or in behalf of the patient. Unless other arrangements are made in advance, payment is due at time services are rendered. I further authorize payment of medical benefits, if any, to the physician and for service described on my statement.

3) **AGREEMENT TO PAY FOR MISSED APPOINTMENTS**: I understand that if I do not call and cancel my appointment 24 hours or more prior to the appointment time, I will be charged a "no show" fee.

4) **PRESCRIPTION MEDICATIONS**: The patient may choose to obtain prescription medications from the patient's pharmacy of choice.

5) **RELEASE OF MEDICAL INFORMATION**: Emerald Coast Mood & Memory P.A. complies with The Health Insurance Portability and Accessibility Act of 1996.

MEDICARE, CHAMPUS and INSURANCE AUTHORIZATION

I do hereby authorize Emerald Coast Mood & Memory, P.A. and Dr. James L. Igleburger, to release any medical information needed in the administration of the Medicare, CHAMPUS, FECA and BLACK LUNG programs. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, other insurance companies and other organizations of Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information such as name or claim number, would delay payment of the claim.

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877(a) (3) of the Social Security Act provides criminal penalties for withholding this information.

I have read the above acknowledgments and agreements, and fully understand the same.

Witness: _________________________________ Signature: ____

Date: ____________________________________ ____

Relationship to Patient

STATEMENT OF PRIVACY

EMERALD COAST MOOD & MEMORY, P.A.

It is the policy of our practice that all doctor and staff preserve the integrity and the confidentiality of **Protected Health Information (PHI)** pertaining to our patients. The purpose of this policy is to ensure that our practice and its doctor and staff have the necessary medical and **PHI** to provide the highest quality care possible while protecting the confidentiality of the **PHI** of our patients to the highest degree possible. Our practice and its doctor and staff will:

- ☞ Adhere to the standards set forth in the Notice of Privacy Practices.
- ☞ Collect, use and disclose **PHI** only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its doctor and staff will not use or disclose **PHI** for uses outside of practice's **Treatment, Payment, and Healthcare Operations (TPO)**, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- ☞ Use and disclose **PHI** to remind patients of their appointments unless they instruct us not to.
- ☞ Recognize that **PHI** collected about patients must be accurate, timely, complete, and available when needed. Our practice and its doctor and staff will:
  - ➢ Implement reasonable measures to protect the integrity of all **PHI** maintained.
- ☞ Recognize that patients have a right to privacy. Our practice and its doctor and staff respect the patient's individual dignity at all times. Our practice and its doctor and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- ☞ Act as responsible information stewards and treat all **PHI** as sensitive and confidential. Consequently, our practice and its doctor and staff will:
  - ➢ Treat all **PHI** data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
  - ➢ Not disclose **PHI** data unless the patient (or his or her authorized representative) has properly authorized the release or law otherwise authorizes the release.
- ☞ Recognize that, although our practice *owns* the medical record, the patient has a right to inspect and obtain a copy of his/her **PHI**. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its doctor and staff will:
  - ➢ Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
  - ➢ Provide patients an opportunity to request the correction of inaccurate or incomplete **PHI** in their medical records in accordance with the law and professional standards.
- ☞ Our doctor and the staff of our practice will maintain a list of certain disclosures of PHI for purposes other than **TPO** for each patient and those made pursuant to an authorization as required by the **Health Insurance Portability and Accessibility Act of 1996 (HIPAA)**. We will provide this list to patients upon written request.
- ☞ Our doctor and the staff of our practice will adhere to any restrictions concerning the use or disclosure of **PHI** that patients have requested and have been approved by our practice.
- ☞ Our doctor and the staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Access to Protected Health Information

Privacy Policy:

Our practice recognizes and respects the fact that the patient has a right to inspect and obtain a copy of his/her **Protected Health Information (PHI)**.

Privacy Procedures to accomplish this Privacy Policy include: ***(continued on next page)***

- The Privacy Officer will provide the front office staff with an original form for patients to complete when the patient desires to inspect and copy his/her **PHI**.
- The front office staff will photocopy and make available to patients the form to inspect and copy **PHI**.
- The front office staff will respond to patients' requests and questions concerning inspecting and copying their **PHI**. In addition, the front office staff will distribute the form to the patients upon their request.
- Once the patient completes the form, the front office staff should forward the form to the Privacy Officer for review.
- Once the patient has submitted his/her request in writing (using the practice's form is optional), the front office staff must verify that the patient's signature matches his/her signature on file.
- The Privacy Officer must review the patient's request and respond to the patient within 30 days from the date of the request. The Privacy Officer can request an additional 30-day extension as long as the request is made to the patient in writing with the reason for the delay clearly explained.
- The Privacy Officer should agree to all reasonable requests. If access is denied, the Privacy Officer must provide the patient with an explanation for the denial as well as a description of the patient's review appeal.
- When the patient has requested to inspect their **PHI** and his/her request has been accepted, the Privacy Officer or other authorized practice representative should accompany the patient to a private area to inspect his/her records and remain with the patient during inspection. After the patient inspects the record, the Privacy Officer will note in the record the date and time of the inspection, and whether the patient made any requests for amendments or changes to the record.
- When the patient's request to copy his/her **PHI** has been accepted, the front office staff should copy his/her record within thirty days at a charge of one dollar per page or as set by Florida state law.

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

EMERALD COAST MOOD & MEMORY, P.A.

I, ________________________ **HAVE READ A COPY OF EMERALD COAST MOOD & MEMORY'S**
Patient name

Notice of Patient Privacy Practices.

________________________ ________________
Signature of Patient or Date
Parent or legal Guardian

____
Witness