Better Mood Clinic, P.C.
2935 North Ashley St, Bldg F
Valdosta, GA. 31602
229-333-CARE

BMC General Information

Welcome to the Better Mood Clinic (BMC). We are glad you are here. For many of you getting here may have been a journey riddled with many challenges. Being here tells us you are committed to your health and a desire to feel better. The following reflects our commitment to you. You can expect the attention, respect, and best professional efforts and quality of care from a team of mental health and service providers. Your providers will treat you and your family member's as responsible individuals and able to take an active part in your intervention and treatment process. BMC is a new integrated mental health care program designed to meet your needs in a very different way. Through the efforts of many behavioral health and or service providers, we will provide you treatment through a seamless system of care. Services may vary from non-clinical to clinical services and cover a range of services from screenings, assessments, case management, consultation and clinical counseling. Depending on your needs and the outcome of your screening, an intervention or treatment plan will be developed with you and/or your family. This plan will help guide us on how to better serve your needs. It is important that you understand the goals and direction of your treatment. If you do not understand, please ask. Further, as with any intervention or treatment program, it is imperative you understand the risks and benefits of your care. For example, a benefit of marital intervention is a healthier and more vital marriage. A risk of intervention might be a separation or worst case scenario, a divorce. Communication and establishing an open and genuine relationship with your treatment team is the key to having effective care and treatment. You, your family, your other medical provider, and possibly a school, are the main components in these processes. Please let your providers know as often as needed on how to help you and/or your family. Please review the following information and initial after each section. One of the BMC staff or your provider will review it with you when it is completed.

Clinic Hours: Initially the BMC will be open from 8:00 until 6:00 Monday through Thursday and on Fridays from 8:00 until 4:00. As we gain more staff and begin more programs we hope to increase our hours to include some evenings and weekends. If you are at risk or become at risk and it is during clinic hours, please call the clinic and one of our clinical staff will help you decide the best course of action. If it is before or after clinic hours, please go to the emergency room or the Greenleaf Center immediately or call 911. If you are not familiar with Greenleaf or the emergency room at South Georgia medical center, please be sure to ask for directions in the event you need to visit either hospital at some time. **Initials:** _____

Types of Appointments: By now we have discussed the reason for your appointment and have appropriately scheduled you with the appropriate provider for the right amount of time. However, your situation my have changed and so may have your needs. If there are any changes please let us know. Additionally, if your appointment involves any legal or specialized medical procedures such as: a psychiatric or mental health evaluation, a forensic evaluation, a court ordered substance abuse assessment due to a DUI, a disability review, a Department of Family and Children Services assessment, a security clearance, an overseas assessment, or a pre-surgical assessment for procedures like bariatric or gastric bypass surgery, let us know immediately. Your insurance likely may not cover the cost of these specialized interventions so we will likely need to adjust your appointment type. Thus, please advise a staff member about any changes in your appointments. **Initials:** _____

Late or Missed Appointments: If you know you will be late (greater than 10 minutes) or miss an appointment please call as soon as possible so we can reschedule you as soon as possible. Failure to show for an appointment or failure to cancel an appointment within 24 hours will be charged at $50.00. This fee may be waived by your provider and any questions concerning the charge should be directed to your provider. Missed appointments ultimately take away from another patient's opportunity to receive care. **Initials:** _____

Insurance and Payments: Prior to your appointment we preauthorized your treatment needs. In turn we will file your insurance claims. We will need to verify who you are through two forms of identification. Additionally payment for the service received as well as your co-pay is due on the day the service was provided. A deductible might also be due. If it is you will be advised. If there are problems with paying your account, please discuss the issue with your provider and an adjustment may be made. However, it is our expectation that you will keep your account current and keep your provider in the loop on concerns that might pre-empt payment.

For payment we accept checks, cash, debit or credit cards. Again, please ensure those accounts are not in the red and the check or cards will not be overdrawn. If a pattern of financial problems or irresponsibility develops, you may be asked to pay a flat rate of $50.00 to cover the additional business expenses that have occurred as a result of your financial distress. **Initials:** _____

Mediation Lists: Each time you will be seen you will be asked to review and/or update you medication list. Keeping your providers in the loop on any mediation changes will ensure responsive and integrated care. Please let us know if you need any additional help or changes. At the present time, we are not affiliated with any discounted pharmacy program? However, if this changes we will let you know. **Initials:** _____

Before engaging in an assessment or evaluation/treatment process, we want you to know some of the privacy ground rules. Generally, information discussed about you and/or your family during any of your interventions will be confidential and may not be revealed to anyone outside this program without your permission. Under some limited circumstances information may be released without your permission. These are discussed below.

Records of Your Care: Every visit or intervention will be documented in your clinical electronic record here at the BMC. Information may be disclosed in furtherance of the rendition of professional comprehensive services, but only with your permission and advisement. Our records are consistent with the latest Health Insurance Portability and Accountability Act of 1996 (HIPAA). HIPAA requirements which limits the unnecessary release of personal health information and only allows the consumer the "minimum necessary" information to be disclosed depending upon specific circumstances and "health care operations" purposes. Please let us know if you have concerns or questions about your records. You have the right to know how and if your information has been tracked and if it has disclosed. By February 2010, all medical records in the United States will be required to be in an electronic format. **Initials:** _____

Federal or State Law or Service Regulation: These statutes impose a duty to report information obtained in a communication.

> **Suspicion of Child or Spouse Maltreatment:** All providers must report all suspected child abuse or neglect to appropriate local child protective authorities. Spouse or elder maltreatment may be reported at your request to the proper authorities.
>
> **Danger to Self or Others**: Providers must take all steps necessary to protect all individuals from harm when a person presents a serious threat to the life or safety of self or others.

Consent to Communicate and Release Information: Most patients have other medical providers, family members or friends involved in your care. Again as noted above, it is our goal to integrate and coordinate your care when possible. In order to meet this goal we need your consent. For example if a family member, doctor or friend calls to ask about your medication or your appointment, we can not disclose this information (your protected health information) without your consent. As a result, we need you to note that you willingly share the names, address and phone numbers of the following individuals to the BMC so that a comprehensive treatment and or intervention plan can be set up for my family or I and the information exchange can be reciprocated. If you do not wish that we communicate with anyone, please write **No One** across the lines. **Initials:** _____

Name (s) of Medical Providers Address Phone numbers

_____

_____

_____

_____

Name (s) of Service Providers Address Phone numbers

_____

_____

_____

_____

Name (s) of Educational Providers Address Phone numbers

_____

_____

_____

_____

Name of Family Member or Friend Address Phone numbers

_____

_____

_____

_____

Please note below how you want us to communicate with you and if we can leave a message. No clinical information will be released to you, only an appointment time; date or appointment change will be noted. If you do not want a message to be left for you, please note this below by writing no messages on the line. **Initials:** _____

Written communications: **Address**: _____
_____
_____

Oral communications: **Telephone**: _____
(Note home, work or cell) _____
_____

Electronically: **E-mail:** _____
_____

I have read and understand the above policies and the responsibility I have for my treatment. I understand that I may change or revoke this authorization in **writing** at any time. Any other release of information will require a signed authorization for release of protected health information (PHI).

_____ _____
Patient Signature Date

_____ _____
Legal Guardian Signature/Relationship to Patient Date
(Must be signed if patient is under 18)

Reviewed with patient: _____ _____
BMC staff or provider Date