deClouet
MENTAL HEALTH SOLUTIONS
Matthew deClouet, APRN, PMHNP-BC
Ellen Ritch, APRN, PMHNP-BC, FNP-C
Heidi Romero, APRN, PMHNP-BC
302 La Rue France, Suite 202 • Lafayette, LA 70508 • 337-534-0971 (o) • 337-534-0974 (f)

Patient Name: _____
LAST FIRST MIDDLE INITIAL

Sex: M F DOB: _____ SSN: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Email Address: _____

Home Phone: _____ Cell: _____ Other: _____

Marital status: _____ Single _____ Married _____ Living with partner _____ Divorced _____ Widowed

PRIMARY INSURANCE

Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Employer/Group Name: _____

Member ID#: _____ Insurance Group#: _____

Patients Relationship to Subscriber: (circle one) l. Patient 2. Spouse 3. Dependent

SECONDARY INSURANCE

Insurance: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Policy Holder SSN: _____

Employer/Group Name: _____

Member ID#: _____ Insurance Group#: _____

Patients Relationship to Subscriber: (circle one) l. Patient 2. Spouse 3. Dependent

Authorization to Discuss Healthcare Information (Specific Individuals)

I authorize deClouet Mental Health Solutions to discuss all healthcare information with the below individuals. I understand that my medical condition & financial standing will be discussed. I also understand this authorization will remain in force and effect until it is revoked in writing.

Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____
Name: _____ Phone: _____ Relationship: _____

I understand that my signature certifies that the information provided is accurate and current.

Signature of Patient/Guardian: _____ Date: _____

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Patient Self-Assessment

Patient Name: _____ Date of Birth: _____

PRESENTING PROBLEMS: Describe current problems and what prompted you to seek treatment: _____

_____

_____

Have you ever received Psychiatric Care? Y N

If yes, list name of provider: _____ Length of time under his/her care: _____

Please list current medications prescribed by psychiatrist or other doctor that you are taking:

MEDICATION	DOSE	FREQUENCY	START DATE	END DATE	PHYSICIAN	SIDE EFFECTS?	BENEFICIAL?

Pharmacy: _____ Pharmacy Phone Number: _____

How are your appetite and sleep pattern? _____

_____

Do you have any known allergies? _____

PREVIOUS PSYCHOLOGICAL AND/OR SUBSTANCE USE PROBLEMS AND TREATMENT

HOSPITALIZATIONS: (For *psychiatric or substance abuse* problems only)

DATES	FACILITY/MD/THERAPIST	PRESENTING PROBLEM	OUTCOME

MEDICAL HISTORY

Primary Care/Family Physician: _____ Date of last physical exam: _____

PATIENT TREATMENT GOALS

List the goals or outcomes you would like to accomplish during your course of care: _____

_____

_____

*Revised Nov2023 -JG

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NAME: _____ DATE: _____

Rapid Mood Screener

Consider your whole life as you answer these questions

Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	**YES**	**NO**
Did you have problems with depression before the age of 18?	**YES**	**NO**
Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	**YES**	**NO**

Have you ever had a period of time during which you were more talkative than normal with thoughts racing in your head?

If yes, what was the longest it lasted for?

- o **NO**
- o **YES, 1-3 DAYS**
- o **YES, 4 OR MORE DAYS**
- o **YES, 7 OR MORE DAYS**

Have you ever had a period of time during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?

If yes, what was the longest it lasted for?

- o **NO**
- o **YES, 1-3 DAYS**
- o **YES, 4 OR MORE DAYS**
- o **YES, 7 OR MORE DAYS**

Have you ever had a period of time during which you needed much less sleep than usual?

If yes, what was the longest it lasted for?

- o **NO**
- o **YES, 1-3 DAYS**
- o **YES, 4 OR MORE DAYS**
- o **YES, 7 OR MORE DAYS**

Mood Disorder Questionnaire (MDQ)

Name: _____ **Date:** _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.*		
◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full mecical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
					Part A
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
					Part B

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CANCELLATION POLICY & CREDIT CARD AUTHORIZATION

Please read the following policy carefully due to severity of our guidelines

In order to provide you and other patients of deClouet Mental Health Solutions the best possible care, a 24-hour notice is **required** to cancel or reschedule your appointments. As a courtesy, when time allows, we make reminder calls and texts for appointments. If you do not receive a reminder call or message, the cancellation policy will remain in effect.

This authorization will allow cards on file to also be charged for remaining balances upon being billed to insurance. If fees-for-service are not collected at the time of service and/or a balance is accumulated after insurance claims are processed, your card will be charged for the entire amount, including the 4% non-cash adjustment fee. We will always call before processing balances, but if no return call is made to set up a payment plan beforehand, you are still responsible for the balance incurred.

- New Patient No Show/Late Cancellation Fee **$175**
- Established Patient No Show/Late Cancellation Fee **$100**

I, _____, understand the importance of notifying deClouet Mental Health Solutions at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. I understand that I will be charged a No-Show fee/Late Cancellation fee of the above stated amount for failing to call or show for my scheduled appointment. I also understand that I am responsible for any and all balances acquired during the course of my treatment.

Cardholder's Name (as on card)

_____

Card Number:

_____

Expiration Date _____ CCV: _____ Billing Zip Code: _____

Patient Name (printed): Patient Signature:

_____

Cardholder's Signature: Date:

_____

IF PATIENT IS NOT CARD HOLDER

I, _____. authorize deClouet Mental Health Solutions to charge my credit/debit card the above stated amount for each No Show/Late Cancellation where 24-hour notice is not given. I certify that this is my credit/debit card and that by signing this agreement on behalf of _____, I am authorizing to give permission for its use to your office.

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Contract for Controlled and Narcotic Substance Prescriptions

Controlled and Narcotic substance medications such as Benzodiazepines, Opiates, and Stimulants are very useful but have potential for misuse; therefore, they are controlled by local, state, and federal government. They are intended to improve function and/or ability to works - not simply to feel good. Due to my provider prescribing these medications for me to help manage my condition, I agree to the following:

1. I am solely responsible for my Controlled and Narcotic Substance Medications and if the medication is lost, misplaced, stolen, or if I take more than is prescribed, I understand that it will not be replaced or filled early.
PATIENT/GUARDIAN INITIAL
_____

2. I will not request or accept Controlled and Narcotic Substance Medications 'from any other physician or individual while I am receiving such medications from deClouet Mental Health Solutions. Besides being illegal to do so, it may endanger my health and wellbeing. The only exception is if it is prescribed while I am inpatient in hospital setting.
PATIENT/GUARDIAN INITIAL
_____

3. Refills of Controlled and Narcotic Substance medications:
   a. Will not be made if I "run out early." I am responsible for taking the medication as prescribed and will not be refilled if taken incorrectly.
   b. Will not be made as an "emergency." I will call 3-5 days in advance if I need assistance or a fill of a controlled and narcotic substance medication prescription.
PATIENT/GUARDIAN INITIAL
_____

4. I understand that if I violate any of the above conditions, my Controlled and Narcotic Substance prescription and/or treatment with deClouet Mental Health Solutions may be terminated immediately. If the violation involves obtaining controlled substances from another individual/provider, as described above, I may also be reported to other healthcare providers, medical facilities, pharmacies, and state and federal authorities.
PATIENT/GUARDIAN INITIAL
_____

5. I understand that the main treatment goal is to improve my ability to function daily. In consideration of that goal and the fact that I am being given potent medications to help me reach that goal, I agree to help myself by the following better health habits and not using "street drugs." I understand that using "street drugs" will impact my progress and counteract with any prescribed medications. Continued use of illicit drugs after warning can be cause for your care to be terminated immediately from deClouet Mental Health Solutions and may be reported to local, state and federal authorities.
PATIENT/GUARDIAN INITIAL
_____

I have read this contract in its entirety and fully understand its content. In addition, I fully understand the consequences of violating this contract and agree to any action that can be taken if violated.

Patient/Guardian Signature: _____ Date: _____

Printed Name(s): _____

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Office Policy

Appointments:

At each appointment, please help us to better serve you by always updating demographic changes (phone numbers, addresses, insurance, etc.) as soon as possible. Patients are seen in scheduled order. Patients that arrive 15 minutes or later after appointment time will be rescheduled. Please also remember that everyone has different needs and because of this, the provider can sometimes run ahead or behind schedule. Please have patience and we will get to you as soon as we can. Remember we are here to help you. If we are behind over 30 minutes, a no-show fee will not be charged.

Financial Policies:

- Self-Pay: If you do not have insurance, we offer a self-pay option. We require that the appointment be paid in full within 5 business days before your scheduled appointment. If we do not receive payment within this time frame, your appointment slot will be given to the next patient in line. Fees for Self-Pay patients are as follows:
    - Initial Visit: $350 (CC or Cash Only)
    - Follow-Up Visit: $200 (CC or Cash Only)

- Private Insurance: deClouet Mental Health Solutions is pleased to participate in several different insurance plans, though it is impossible for our office staff to be aware of each plan's specific requirements. It is your responsibility to verify that we are a member of your network before receiving treatment. It is also your responsibility to know your plan's benefits. Your plan may have limitations on the frequency of services performed, the location of services, the types of services, and/or whether a referral from your PCP is required for coverage. It is the patient's responsibility to inform deClouet Mental Health Solutions of specific limitations set by their insurance plans at the time of scheduling. If deClouet Mental Health Solutions orders services that are not covered by a patient's insurance, payment for these services becomes the financial responsibility of the patient. You are financially responsible for any changes that may occur with your insurance during the course of treatment.
    - If we participate in a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. You will be responsible at the time of services for your deductible, co-payments, and non-covered medical or mental health charges. In the event that we are not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier. You will be responsible for any and all charges not covered by your insurance carrier.

- Medicare: deClouet Mental Health Solutions will bill Medicare and any supplements needed. You will be responsible at the time of service for payment of the annual deductible, co-payments, co-insurance, and charges for your non-covered mental health services.

- Billing and Collections: Payment is required to be paid in full before or at the time of all services rendered. They are Fee-for-Service, regardless of the amount of time spent for each appointment. deClouet Mental Health Solutions accepts payment in the forms of: Cash, Check, VISA, MasterCard, Discover, and American Express. If payment is made via debit, credit, or HSA card, a 4% non-cash adjustment fee will be applied. If you receive an invoice from our office for a balance due, your insurance did not pay either entirely or a portion. Please call your insurance carrier

first if you believe there is a problem. If there is a discrepancy, please call the office. Otherwise, you are responsible for all remaining balances.

- Non-Covered Services by Insurance:
  - **NSF Checks:** There is a $50 charge for all NSF checks. You will be responsible for the amount owed plus the NSF fee within 30 days from the date the check was written to avoid additional fees or collection action. **This can only be paid in Cash or CC**
  - **No Show and Late Cancellations:** There is a $175 charge for initial appointments and a $100 fee for follow-up appointments. (See Cancellation Policy for further information)
  - **Form Completion:** There is a $100 base fee for paperwork completed for a patient that is compliant with treatment for a minimum of 6 months. Examples of these are: Social Security, Disability, FMLA, Insurance Forms, Travel Forms, Return to Work Forms, Service Animal Letter, etc. The fees must be paid before we can send paperwork anywhere. **These can only be paid in Cash**
  - **Prior Authorizations for Medication:** There is a $15 fee for any Prior Authorization needed by your insurance. **These can only be paid in Cash**
  - **Psychiatric Clearance for Surgery:** There is a $350 base fee for psychiatric evaluations to clear patients for surgery from an outside provider. **This can only be paid in Cash or CC**
  - **Late Fee:** If a balance becomes more than 45 days past due, a late fee may be assessed.
  - **Reprint Fee:** If a printed prescription is misplaced or lost, the patient is responsible for a $15 reprint fee.
  - **Credit Card Terminal Fee:** There is a 4% non-cash adjustment fee applied to each transaction due to terminal charges. (See Debit/Credit/HSA Card Authorization Policy for further information)

Cancellations and Reschedules:
Please help us better serve you and other patients by keeping all scheduled appointments. If you must change/cancel an appointment, please do so 24 hours prior to your scheduled appointment time. Monday appointments must be canceled by 12 PM the preceding Friday. The charges for a no-show/late-cancel appointment is $175 for an initial and $100 for a follow-up if we do not receive notice from you 24 hours prior to your appointment and the appointment is missed, regardless of the reason. This includes missing the telehealth call (if applicable), being ill, out of town, at work, or being a caretaker. **These charges can only be paid in Cash or CC and must be paid prior to rescheduling next appointment.**

Lab Results:
Lab tests and/or Pathology specimens sent to outside laboratories will be billed separately from deClouet Mental Health Solutions. The laboratory will bill you and/or your insurance carrier separately from our services. The patient is responsible for any fees incurred.

Medication Refills:
It is your responsibility to call the office at least 3-5 days BEFORE you run out of medication. Prescription refills are processed Monday through Thursday only (Refills are not processed on Friday, weekends, or holidays). Controlled Substance and Narcotic Medications require an office visit and will not be called in unless the patient is seen by provider. If you miss an appointment, refills for any Controlled Substance or Narcotic Medication will NOT be sent in. No Exceptions!

Debit/Credit/HSA Card Authorizations:
A current debit/credit/HSA card will be kept on file. This will be used for any co-payments, deductibles, or cancellation fees. A copy of your receipt can be e-mailed or mailed to you upon request.
There is a 4% non-cash adjustment processing fee for all card transactions

Patient Dismissal: While we make every effort to work with our patients, sometimes we feel it may be best for all involved that you be dismissed from the practice. If you are dismissed, a discharge letter will be mailed to the address on file, as well

as a 3-month supply of your medication (if deemed necessary - this is at the provider's discretion). The medication will be sent to the pharmacy on file. At this time, you will need to seek services from another provider. Common reasons for dismissal are failure to keep appointments are frequent cancellations, more than 3 no-shows, non-compliance of treatment plan, verbal/physical abusiveness to staff/providers, failure to pay patient balances or unwillingness to comply with office policies.

Medical Records: Please allow 7-10 business days for processing. There is a $25 administrative fee for production of records. For pages 1-25 it is $1.00/page, pages 26-350 it is $0.50/page, and for 351+ pages it is $0.25/page.

I hereby authorize the assignment of benefits and payments directly to deClouet Mental Health Solutions. Your signature below signifies that you understand our Financial and Office Policy. You agree to the terms stated and it is your responsibility to take care of any charges incurred at this office.

Signature of Patient or Guardian:

_____

Patient Name (Printed):

_____

Date:

_____

Witness Signature (Office Staff Only):

_____

*Revised Jun 2024-JG

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HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this carefully.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff, and others outside of this office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physicians practice and any other use required by law.

Treatment: To provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party.

Payment: To obtain payment for health care services or third-party payers.

Healthcare Operations: We may use or disclose your PHI in the following situations without authorization:
Public Health Issues as required by law, Communicable Diseases, Health Oversight, Enforcement, Coroners, Funeral Directors, Military Activity, National Security, and Worker Compensation. Other permitted and required uses and disclosures will be made only with your consent, authorization, and opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your provider or the provider's practice has taken an action in reliance on the use or indicated in the authorization.

Your Rights: You have the right to review your protected health information. Under federal law, however, you may not review or copy the information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information. You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your protected information for the purposes of treatment, payment, or healthcare operations. Your provider is not required to agree to a restriction that you may request. If your provider believes it is in your best interest to permit use and disclose of your PHI, your protected health information will not be restricted. You then have the right to use another healthcare professional. You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. You have the right to physically amend your PHI. If we deny your request for amendment, you have the right to file a statement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal. We are required by law to maintain the privacy of and provide with this the notice of our legal duties and privacy practices with respect to PHI.

Consent for Treatment: I authorize, deClouet Mental Health Solutions, its staff and attending physicians to render to the patient all customary care, therapy, treatment, considered advisable, including emergency treatment and transportation to another facility if necessary. The undersigned agrees that deClouet Mental Health Solutions will not be responsible for the safety or care of the patient if the patient leaves the premises and will indemnify deClouet Mental Health Solutions from any loss or injury which occurs as a result of leaving against medical advice. The undersigned acknowledges that the patient is under the care of providers and deClouet Mental Health Solutions is not liable for any act or omission in following the

instructors of said provider(s). The undersigned further recognizes that the patient is responsible for any health insurance deductible, federally mandated co-insurance, and non-covered charges for provider(s).

Consent for Release of Information: I authorize deClouet Mental Health Solutions to release all patient information, including specific information regarding diagnoses, treatment and prognosis with respect to any physical, psychiatric, or drug/alcohol related condition for which the patient is being treated, including treatment for Acquired Immune Deficiency Syndrome (AIDS), while a patient of deClouet Mental Health Solutions to any insurance company and/or third party payors, or representative of deClouet Mental Health Solutions to an appropriate representative of deClouet Mental Health Solutions, including but not limited to employees (as applicable by HIPAA laws), attending physicians, or other health care professionals or organizations. This information may not be released to any other person or entity unless the undersigned so authorizes. I acknowledge that such disclosure shall be limited to information that is reasonably necessary for the billing of the legal or contractual obligations of the person(s) or entities to which the information is released. I further authorize, deClouet Mental Health Solutions to release information for the purpose of obtaining authorization or treatment, release the information to medical review agencies, and/or third-party payors providing coverage or having responsibility for these services.

Guarantee of Payment/Financial Responsibility: I agree to guarantee the payment of the bill for services rendered by deClouet Mental Health Solutions. I agree whether signing as guarantor or as patient, that in consideration of the services to be rendered to the patient, to be hereby jointly and individually obligated to pay the account in accordance with the regular rates and terms of deClouet Mental Health Solutions. I agree that I am responsible for any health insurance deductible, federally mandated co-insurance, office policy fees, and non-covered charges (Self-Pay: Initial $350 and Follow-Up $200 CC or Cash Only). Should the account be referred for collection, I will be responsible for charges that are necessary for the collection of any amount(s) not paid when due.

Assignments of Insurance Benefits: In consideration of medical services rendered or to be rendered by deClouet Mental Health Solutions to the extent permitted by law. I hereby (i) irrevocably assign, transfer and set over to deClouet Mental Health Solutions (ii) all of my rights, title and interest to medical reimbursement, including not limited to, (iii) the right to designate a beneficiary, add deemed eligibility and (iv) to have an individual policy, subscription certificate or other health benefits indemnification agreement otherwise payable to me for those services rendered by the corporation during the pendency of the claim, Such irrevocable assignment and transfer shall be for the recovery on said policy(ies) of insurance, but shall not be constructed to be an obligation of corporation to pursue any such right of recovery. I hereby authorize the insurance company(ies) or third-party payor(s) to pay deClouet Mental Health Solutions all benefits due for services rendered.

Acknowledgement of Receipt of HIPAA Privacy Practices: I, individually or as the personal representative of the patient, acknowledge that I was given a copy of deClouet Mental Health Solutions HIPAA Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can get access to this information.

I understand that my signature below certifies that I have read and understand the above consents and/or statements.

Patient's Printed Name _____

Signature of Patient/Guarantor _____

Date _____

deClouet
MENTAL HEALTH SOLUTIONS

Matthew deClouet, APRN, PMHNP-BC
Ellen Ritch, APRN, PMHNP-BC, FNP-C
Heidi Romero, APRN, PMHNP-BC

302 La Rue France, Suite 202 • Lafayette, LA 70508 • 337-534-0971 (o) • 337-534-0974 (f)

Consent for Provider Use of Artificial Intelligence (AI) for Medical Appointment Documentation

Patient Name: _____ **Date of Birth:** _____

As part of our commitment to providing high-quality and innovative care, deClouet Mental Health Solutions' providers may use Artificial Intelligence (AI) tools to assist with documentation during your medical appointment. These tools may also help with tasks such as reviewing symptoms, suggesting possible diagnoses, or recommending treatment options.

What You Should Know:

- **AI as a Support Tool:** AI does not replace your healthcare provider. All medical decisions are made by a licensed professional who reviews and validates the AI's suggestions.
- **Data Privacy:** Your medical data will be handled in accordance with HIPAA and other relevant data protection regulations. AI tools used in your care follow strict privacy and security standards.
- **Benefits:** AI can help improve efficiency, enhance diagnostic accuracy, and support more personalized care.
- **Risks:** Although AI tools are tested and regulated, they are not infallible. There may be rare instances of incorrect suggestions or technical limitations.
- **Your Choice:** Participation is voluntary. You have the right to decline the use of AI in your care without affecting the quality of service you receive.

Consent

☐ I understand the role of AI in my medical care and consent to its use during my appointment.
☐ I do **not** consent to the use of AI during my appointment.

Patient (Guardian/Legal Representative) Signature: _____ **Date:** _____

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Authorization for Obtainment of Records

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Phone #: _____

For Record Release or Copies: By signing this authorization, I authorize the party listed below to use and/or disclose certain personal protected health information (PHI). I understand this authorization is valid for 1 year following the date stamp with patient's signature.

This authorization permits: to release or disclose to:

Provider's Name: _____ Provider's Name: deClouet Mental Health Solutions

Street Address: _____ Street Address: 302 La Rue France, Suite 202

City, State, ZIP: _____ City, State, ZIP: Lafayette, LA 70508

Phone: _____ Fax: _____ Phone: 337-534-0971 Fax: 337-534-0974

Information to be Released/Copied:

- All medical records including but not limited to, diagnoses, evaluations, office visits, inpatient hospitalizations, & medications including those related to alcohol &/or drug abuse &/or mental health, if any.
- Day sheets - dates: _____
- Lab Info - dates: _____
- Other: _____

Specific Information to be Excluded: _____

Reason for Record Release or Copy: ( ) Personal Copy ( ) Over age 18 ( ) Moving ( ) Insurance Change (please state insurance) ( ) Referral to Specialist) ( ) Changing Provider and/or Practice ( ) Continuity of care ( ) Other

_____

Patient/Guardian Signature Date

_____

Patient Name (printed) DMHS Staff Witness Signature

deClouet
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_____

Patient/Guardian Signature Date

_____

Patient Name (printed) DMHS Staff Witness Signature