Intake Appointment: ___________________________________

Updated 4/22/21

Harris Robert Jensen, MD, LLC

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Please initial & date each page to indicate you understand these policies. Ask us questions if you don't understand something. Thank you, and welcome!

Patient Name: ____ **Date:** _____________

Guardian Name: ____

Philosophy

Welcome to my office! I provide psychiatric assessment and treatment of adults and adolescents age 12 and older. I consider the four main components in life to be the medical, psychological, social, and environmental factors. If we represented life as a chair with four legs, those four factors would each be one "leg," providing support, balance, and helping to stabilizing the chair, or life, as a whole. Weakness in one or more legs leads to instability and causes the chair, or one's life, to not function well.

I am committed to providing the highest quality of care for my patients, so they can control and stabilize their life. My recommendations are based on the latest medical science research, as well as over 20 years of experience working in the field. You can read more about my philosophy and practice, as well as office policies, at:

harrisjensenmd.com

or

gooddayjournal.com/harrisjensen

My approach is to work through issues while building the skills a patient needs to be happy. Primarily, my practice focuses on interpersonal skills, meditation, rational thinking skills, and/or using medication. Together you and I will focus on building up your self-resilience by improving your insight into yourself and how best to meet your specific and unique needs.

Please take a few minutes to read, fill out, and sign the following information.

Office Use Only			
Ins Info Scanned		Insurance Info Entered	
Copy of Policies/Checklist		Packet Scanned	
CC Auth Signed/Appt Made		Packet/Ins Uploaded	
Chart Created		PDMP Check Completed	

Updated 4/22/21

New Patient Information

*** Please print clearly and legibly- mistakes will cause insurance claim rejections! ***

Demographics:

Name:		
Date of Birth:	Age:	
Social Security Number:	Sex:	
Marital Status:		
Address:		
City:	State:	Zip:
Cell Phone:	Home/Work/Alt Phone:	
Can we text you appointment reminders?		
Email (*optional, used for e-Statements*):		
Emergency Contact:		
Relation:	Phone:	

Not using insurance? Please ask for a Price List for self-pay clients, ignore any insurance questions/sections below, and check the box to the right → **Self-Pay Costs** ➢ First Appointment 45 min- $300 ➢ Follow-up/Med Check 30 min- $200 ➢ Follow-up/Med Check 15 min- $100	**Self-Pay:**	

Insurance Billing Information:

We are no longer taking Tricare, Medicaid, or Workman's comp for new patients.

Primary Insurance Provider:	Plan Effective Date:
Member ID:	Group #:
Secondary Insurance Provider:	Plan Effective Date:
Member ID:	Group #:

Primary Policy Holder's Information: *(Leave blank if same as above)*

Policy Holder's Name:		
Relationship to Patient:	Sex:	
Date of Birth:		
Address:		
City:	State:	Zip:
Phone:		
Can we speak with this person about insurance questions or issues?		

If Patient is a Minor:

Guardian:	Phone:	
Relationship:	Social Security:	
Address (if different):		
City:	State:	Zip:

Updated 4/22/21

E-Prescribing Pharmacy Information:		
Name of Pharmacy:		
Address:		
City:	State:	Zip:
Phone Number:	Fax Number:	

Please summarize why you are seeking Dr. Jensen's assistance:

The Doctor Patient Financial Agreement

I understand that services need to be paid for at the time they are provided. I understand that I need to keep my account current in order to get further services like scheduling visits with the Dr. etc. I understand that there are no payment plans. If I am short on funds for my account, I agree to use a credit card.

It is REQUIRED that the patient call their insurance provider before their first appointment and verify we are a participating provider, the patient's specific plan benefits, co-pays, deductibles, and to understand how much the patient will ultimately be liable for. ASK FOR A "VERIFICATION OF BENEFITS STATEMENT" sent via mail or email. It outlines exactly what the insurance company agrees to pay for so there are no surprises when you are billed. If you have 2 different insurances, you need to call both insurance companies. Please make sure your Coordination of Benefits (COB) is up-to-date. **Our office DOES NOT verify your insurance; you must do this yourself**

- Insurance Payment and Claim Rejection Process: After your appointment, our office will send a claim to your insurance company. Sending a claim doesn't guarantee your insurance will pay. Claims are often rejected due to minor inaccuracies in address, ID numbers, misspelled names, or missing/switched numbers or letters. Please note, it is the insurance company's choice to pay or not pay and our office has no control over them.
  - If a claim is denied, our office will try to investigate and fix the problem. However, due to the large quantity of paperwork we have, there is no guarantee the office staff will have time to investigate any specific denial. It is ultimately the patient's responsibility to advocate for themselves and work with their insurance provider by calling the customer service number on their insurance card. Once the issue is resolved our office will re-file the claim.

- Explanation of Benefits: According to Colorado state law, insurance companies must provide an "explanation of benefits" (EOB) to both the provider and patient within 30 days of receiving a claim, whether it is rejected or not. The EOB is usually a physical letter sent to the patient's billing address. Although now they are often available through an online portal if your insurer has one. If you don't receive an EOB within 30-40 days of your appointment, you should call the customer service number on the back of

your insurance card and request one.

Past Due Accounts

- **Interest:** We reserve the right to bill 1.5% finance, as provided by state law, on account balances that are 90 days or more past due.
- **Collections:** Accounts that are 90 days or more past due, where the patient hasn't contacted us, or if we haven't been able to contact the patient after numerous attempts, will be referred to a collection agency. Accounts turned over to collections will result in automatic dismissal as our patient.
- **Returned Check Fee:** Any returned (insufficient funds/NSF) checks will be charged $20.00 plus a $15.00 office fee or whatever the Bank Fee is plus $15.00. The minimum charge billed to your account is **$35.00.**
- For past due accounts, the additional applicable court and attorney fees will also be your responsibility**.**

I agree to these items above:

_______________________________ _______________

Signature Date

Agreement to Bill Insurance

This agreement allows our office to submit charges for services to your insurance on your behalf. It also states that you are ultimately responsible for paying the bill, as well as any late fees.

I AUTHORIZE PAYMENT OF PSYCHIATRIC BENEFITS DIRECTLY TO HARRIS R. JENSEN, MD, LLC. IF MY INSURANCE DOES NOT PAY 45 DAYS AFTER THE BILL WAS SUBMITTED, THEN I UNDERSTAND I AM RESPONSIBLE FOR PAYING THAT BILL. I WILL BE REIMBURSED IF INSURANCE PAYS FOR THE SERVICES AT A LATER TIME. I UNDERSTAND I MAY BE CHARGED ADDITIONAL LATE FEES AND OFFICE CHARGES IF I DON'T PAY MY BILL WITHIN 30 DAYS.

Signing below designates that I have read, understand, and agree to the above paragraph.

_______________________________ _______________

Signature Date

Agreement for Additional Services

I understand that some additional services I may request from this office (missed appointment fees, phone consults, written reports, review of records, record copying, paperwork fees, authorizations required by insurance (PARs), early medication refills, etc.) may not be covered or paid for by my insurance company. I understand services will only be provided when they are paid for in advance. I can keep a positive balance in my account for this.

Signing below designates that I have read and understand the above information.

_______________________________ _______________

Signature Date

<u>Late Cancelation and No-Show Policy</u>

Appointment reminders are sent via an automated text. *We do not give reminder calls.*

PLEASE READ AND INITIAL EACH LINE

_____ Reminders are a courtesy. It is ultimately MY (the patient's) responsibility to remember the date and time of my appointment.

_____ Any cancellations made with less than **<u>48 hours'</u>** notice will be charged a <u>$100.00</u> missed appointment/late cancel fee. Timing will be counted down to the minute. 47 hours and 49 minutes is under 48 hours.

_____ Cancelling or no showing more than 4 times within one calendar year will lead to an evaluation by the doctor, as a transfer of services may be needed.

I agree to these items above:

________________________________ ___________________

Signature Date

Payments for Services

______ I understand that I am ultimately responsibility for payment for any services I receive from this office. I understand that there are services performed by this office that may not be covered by my insurance and that I am responsible for those charges.

☐

Name: ____

Email address: ____

Thank you for committing to this agreement and remember,
<u>you are worth the effort</u>!

Please let us know if you have any questions or concerns.

-Thank you,
Dr. Harris Jensen and Staff

____________________________________ ________________
Signature of Client or Responsible Party Date

____
Printed name

____________________________________ ________________
Signature of Guardian or Co-Responsible Party Date

____
Printed name