St. Francis Xavier
Psychiatric Services, LLC

18 Campus Blvd
Ste 100 - 1696
Newtown Square, PA 19073
484-326-5392 (P), 304-853-5130 (F)
https://stfrancisxavierpsychiatric.com/

Patient Demographic Information Form

Patient Name: ____

Date of Birth: ____________ Age: ____ Sex: [ ] Male [ ] Female [ ] Other

Address:____

City: _________________________ State: ________ ZIP: ______________

Phone (Home): ____________________Phone (Cell):______________________

Email Address: ____

How May We Contact You? ______________

Primary Insurance: _______________________ Policy Number: _______________

Secondary Insurance: _____________________ Policy Number: _______________

Primary Care Provider:

Name: ____

Address:____

Phone: _________________________ Fax: _________________________________

Pharmacy Name: ____

Pharmacy Address: ____

Pharmacy Phone Number: ____

Emergency Contact:

Name: _______________________________ Relationship: ____________________

Phone (Home): _______________________ Phone (Cell): _______________________

Name: _______________________________ Relationship: ____________________

Phone (Home): _______________________ Phone (Cell): _______________________

Medication Refills Policy

The following policies are designed to improve the efficiency of the office and communication between you and the staff of St Francis Xavier Psychiatric Services, LLC. Please read and sign at the bottom of the page to indicate your understanding of the policies.

It is your responsibility to fill your prescription before you run out of medications, and to protect your medications and controlled substances very carefully. Your pharmacy may not allow refills prior to the prescribed date. Our office will NOT accept refill requests from the pharmacy for controlled substances.

St Francis Xavier Psychiatric Services, LLC does not prescribe controlled medications (medication with high abuse potential) for patients with a history of substance abuse. For example, if a patient has formerly abused methamphetamine, we will NOT prescribe any stimulant. Also, we do not refill lost, misplaced, stolen or otherwise unavailable controlled medication. We also do **NOT** offer early refills for these medications. Repetitive requests of this nature will be declined. It is your responsibility to fill your prescription before it expires.

Reasons such as: “I went up on the dose on my own”, “The airline lost my luggage which contained my medications”, “I opened my medication above the sink and it fell in”, etc, are **Not** valid reasons for early refills of medication. Should your medication be stolen, we require a police report prior to submission of the refill.

Per CDC guideline, refills of prescriptions require periodic office visits with the doctor. It is important to comply with your scheduled doctor’s visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Schedule visits must be followed in order for the prescription(s) to be filled.

______________________	______________________	______________
Printed Name of Patient	Signature	Date

Disability/FMLA Paperwork Consent

Any new patient request for Disability/FMLA paperwork requires that the patient will be seen at the clinic for a minimum of 3 visits. It is under the provider's discretion to determine if the patient qualifies for disability regarding current psychiatric conditions. This does not guarantee that the patient's employer will approve the claim. All disability/FMLA paperwork is billed to the patient and not their insurance as an in-office fee of $150. This fee will be due again if renewal is required after 6 months. Payment will be required in full prior to the paperwork being completed.

______________________________ ______________________

Signature of Patient Date

Notice on the Use of AI for Transcribing Medical Notes

At St Francis Xavier Psychiatric Services, LLC, we use HIPAA-compliant AI transcription software to assist us in accurately transcribing the medical notes during your visit. This helps to enhance the efficiency of your healthcare experience. The use of AI technology does not substitute for our listening attentively to you. Rather it is an aid in that process. We do not sell nor distribute these notes. The notes are still covered by your HIPAA rights.

The conversations from our appointments will be transcribed and summarized using HIPAA-compliant technology. No recordings are stored by the system. These summarized notes may be included in your confidential medical records.

Any use of technology carries an inherent risk of unauthorized disclosure. You can bolster the privacy of our communications by using secure, trusted networks and password-protected devices for our appointments. While names and other identifiers are removed, researchers associated with the technology will have access to de-identified session transcripts. It's possible that the system may contain unintentional biases in the summarization process. This risk is offset by our ongoing commitment to carefully review and edit notes using our clinical expertise.

The automated system allows us to dedicate more attention to the appointment process. It eliminates the need for manual notetaking, thereby aiding memory and focus during and after our appointments. This technology helps in reducing our workload, which could potentially alleviate professional fatigue on our end. The system might offer additional clinical insights that could positively influence the outcomes of our appointments.

By proceeding with appointments, you acknowledge and accept these terms.

Should you have any concerns regarding our use of AI, please feel free to reach out to us.

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Patient signature	Date

Notice of Privacy Practices of St. Francis Xavier Psychiatric Services, LLC

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

St Francis Xavier Psychiatric Services, LLC, (collectively referred to as "We", below) are required by law to maintain the privacy and security of your protected health information (PHI). PHI is defined as any health information that identifies you or that could be used to identify you. The law also requires that We provide you with this Notice of Privacy Practices. This notice describes the legal duties and privacy practices that We must follow regarding the use and disclosure of PHI. This notice also describes your rights related to your PHI. We are required by law to let you know promptly if a breach occurs that may have compromised the privacy or security of your PHI. We can change the terms of this notice, and the changes will apply to all PHI We have about you. We will notify you of any changes and the new notice will be available on our website and, upon request, in our office.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We typically use or share your health information in the following ways:

● Treatment: We can use your PHI and share it with other professionals who are treating you.

● Payment: We can use and disclose your PHI to bill and collect payment from you or other appropriate entities.

● Healthcare Operations: We can use and disclose your PHI to run our practice, speak with your other providers, speak with your pharmacy, improve your care, leave you voicemails, email you, and contact you when necessary. These activities include, but are not limited to, calling you by first name in the waiting room when We are ready to see you and contacting you to remind you of an appointment.

We are allowed or required to share your information without your consent or authorization in the circumstances outlined below. We have to meet many conditions in the law before We can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

● Suspicions of Abuse, Neglect, or Imminent Harm: We will be required to use or disclose your PHI to the appropriate government agency if there is any suspicion of child or elder abuse and/or neglect, or when deemed necessary to prevent a serious threat to your health or safety, or the health and safety of others. We are required to report any threats to harm a third party to law enforcement and the subject of the threat.

● Legal Proceedings: We will use or disclose your PHI when required to do so by local, state, or federal law. Therefore, We may use and disclose your PHI for judicial and administrative proceedings as required by a court or administrative order, or in response to a subpoena, discovery request, or other legal processes. Your PHI may also be disclosed if required for our legal defense in the event of a lawsuit.

● Additional Issues of Public Health & Safety: Your PHI may be disclosed, and may be required by law to be disclosed, for public health and safety risks. This includes: to prevent or control disease;

report births and deaths; report adverse reactions to medications or problems with health products; and to help with product recalls.

● Workers' Compensation: If you file a workers' compensation claim, We will be required to file periodic reports with your employer which shall include relevant information about history, diagnosis, treatment, and prognosis. HIPAA Notice of Privacy Practices 2

● Minors (Under Age 14): The PHI of clients who are under the age of 14 will be disclosed to their parents or legal guardians, unless prohibited by law. Under Pennsylvania law, clients who are 14 years of age or older control the release of their own mental health records, except as noted elsewhere in this document.

● Other Special Circumstances

○ For law enforcement purposes or with a law enforcement official in limited situations, such as when information is needed to locate a suspect or stop a crime

○ For special government functions such as military, national security, and presidential protective services

○ Working with a medical examiner, coroner, or funeral director when an individual dies

USES AND DISCLOSURES THAT MAY BE MADE EITHER WITH YOUR AGREEMENT OR OPPORTUNITY TO OBJECT

For certain health information, you can tell us your choices about what We share. In these cases, you have both the right and choice to tell us to:

● Share information with a family member, close friend, or others involved in your care

● Share information in a disaster relief situation

● Include your information in a hospital directory.

If you are unable to agree or object to such a disclosure, for example if you are unconscious, We may disclose PHI as necessary if We determine that it is in your best interest based on my professional judgment.

USES AND DISCLOSURES THAT REQUIRE YOUR WRITTEN AUTHORIZATION

Any other use or disclosure of PHI, other than those listed elsewhere in this document, will only be made with your written authorization (unless otherwise permitted or required by law). Authorization may be revoked at any time, in writing, except to the extent that We have already used or disclosed PHI in reliance on that authorization.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

● Right to Inspect and Copy: You can ask to receive a copy of your PHI in your clinical record. You must submit your request in writing. We will respond to all requests to inspect and copy PHI within 30 days. You are entitled to receive a copy of these records, unless We believe that seeing them would be emotionally damaging. If this is the case, We will be happy to provide a summary of your records to an appropriate mental health professional of your choice, or to prepare an appropriate summary for you instead. Because client records are professional documents, they can be misinterpreted and can be upsetting.

● Right to Request a Correction or Amendment to Your Clinical Record: You can ask us to correct or amend PHI about you that you think is incorrect or incomplete. You must submit your request in writing and must include the reason for the request and any supporting documentation. We have the right to say "no" to your request but, in this event, We will tell you why in writing within 60 days.

● Right to Request Confidential Communications: You can ask us to contact you in a specific way (e.g., home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests. HIPAA Notice of Privacy Practices 3.

● Right to Request Limits to Use or Sharing: You can ask us not to use or share certain PHI for treatment, payment, or practice operations. We are not required to agree to your request, and We may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or health care operations with your health insurer. We will say "yes" unless a law requires us to share that information.

● Right to Obtain an Accounting of Disclosures: You can ask for a list (accounting) of the times We have shared your PHI for 6 years prior to the date you ask, who We shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

● Right to Obtain a Paper Copy of This Privacy Notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

● Right to Choose Someone to Act For You: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will make sure the person has this authority and can act for you before We take any action.

● Right to File a Complaint If You Feel Your Rights are Violated: If you have questions about this notice or have other concerns about your privacy rights, you may contact us at 484-326-5392 or communicate your concerns by sending a written complaint to us at 18 Campus Blvd, Ste 100 – 1696, Newtown Square, PA 19073. If you believe your privacy rights have been violated, you can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/ocr/privacy/hipaa/complaints/.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

1. The Privacy Notice includes a complete description of the use and /or disclosures of my personal health information ("PHI") necessary for the Practice to provide treatment to me, and also necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
2. The Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: calling my home and leaving a message on my answering machine or with the individual answering the phone and text messages.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) in order for the Practice to treat me and obtain payment for the treatment, and necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, the Practice is required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, it is binding on the Practice.
6. I understand that this Consent is valid and that I have the right to revoke this Consent, in

writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already taken action in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
9. The privacy Notice of St Francis Xavier Psychiatric Services, LLC (the "practice") has been provided to me prior to signing this consent. The practice has explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. I have read and understood the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

____________________________ _________________________________

Signature of Patient Date