Child & Adolescent
Psychiatric Services of Maine
Peter Y. Kang, DO
Board Certified Child and Adolescent Psychiatrist

New Patient Information – PLEASE COMPLETE PRIOR TO INITIAL VISIT

Patient Name: _____ Today's Date: _____

DOB: _____ SSN: _____ Marital status: **S / M / D / W**

Name of Person Completing this Form: _____

Relation to Patient: _____ ☐ **Not Applicable**

Primary Address/Residence: _____

Preferred phone #: _____ Okay to leave messages? ..... **Y / N**

Work phone #: _____ Okay to leave messages? ..... **Y / N**

Email Address: _____ Okay to use? ..... **Y / N**

Telehealth Email Address (if desired): _____

Alternate Address: _____

Relation to Patient: _____ ☐ **Not Applicable**

Contact phone #: _____ Okay to leave messages? ..... **Y / N**

How would you like to be reminded of your appointments? ☐ **phone** ☐ **email** ☐ **text**

Employer (or name of school/grade level): _____

Occupation: _____ ☐ **Full-time** ☐ **Part-time**

PRIMARY PERSON RESPONSIBLE FOR CHARGES

Name of Guarantor: _____

DOB: _____ SSN: _____

Address of Guarantor: _____

Contact phone #: _____ Relation to Patient: _____

Health insurance: _____ Prescription coverage? **Y / N**

Policy #: _____ Group #: _____

REFERAL SOURCE:

Who referred you to CAPS of Maine? _____

Reason for referral: _____

Contact number for referral source: _____

EMERGENCY CONTACT INFORMATION:

Name: _____ Relation to Patient: _____

Address: _____

Contact phone #: _____ Okay to leave messages? ..... **Y / N**

Medical History

PRIMARY CARE PROVIDER: ☐ **CHECK BOX IF NONE**

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Date of last visit: _____ Frequency of visits: _____

CURRENT / FORMER PSYCHIATRIC PROVIDER: ☐ **CHECK BOX IF NONE**

Name: _____

Phone: _____ Fax: _____

Date of last visit: _____ For how long? What year(s)?: _____

Additional Psychiatric Providers:
Please list NAME(S) **Year(s) you worked with them**

CURRENT / FORMER THERAPIST/COUNSELOR: ☐ **CHECK BOX IF NONE**

Name: _____

Phone: _____ Fax: _____

Date of last visit: _____ For how long? What year(s)?: _____

Additional Therapists:
Please list NAME(S) **Year(s) you worked with them**

Medical History (Continued)

SPEECH AND LANGUAGE / PHYSICAL THERAPY / OCCUPATIONAL THERAPY:

Name of Organization **Dates of Service** ☐ **CHECK BOX IF NOT APPLICABLE**

CURRENT MEDICATION(S): ☐ **CHECK BOX IF NONE**

(Please include nutritional supplements, herbal supplements, and over-the-counter medications)

Name of medication and approximate start date | Dose | Frequency | Reason prescribed

PAST PSYCHIATRIC MEDICATIONS TRIALS, RESPONSE, AND WHEN /HOW LONG PRESCRIBED:

_____

_____

_____

_____

Do you or your child smoke? **Y / N** If yes, who, how much, and for how long? _____

Do you or your child drink? **Y / N** If yes, who, how much, and for how long? _____

Does the patient have any past or present substance abuse concerns (prescription or illicit)? **Y / N**

If yes, how much and for how long?

_____

PAST SUBSTANCE ABUSE TREATMENT (INPATIENT, OUTPATIENT, NA/AA):

_____

_____

Medical History (Continued)

SPECIALISTS SEEN (AT ANY POINT IN THE PAST):

☐ **CHECK BOX IF NONE**

__allergist
__cardiologist
__cardiothoracic surgeon
__dermatologist
__ear, nose, throat specialist
__endocrinologist
__gastroenterologist
__general surgeon
__hematologist
__infectious disease specialist
__nephrologist
__neurologist
__neurosurgeon
__oncologist
__orthopedic surgeon
__pain specialist
__plastic surgeon
__pulmonologist
__rheumatologist
__urologist
__sleep specialist
__OB/Gyn (other than routine)
__opthalmologist (other than routine)
__internist (other than routine)
__OTHER_____

HAVE YOU EVER HAD :

☐ **CHECK BOX IF NONE**

__seizures
__blackouts
__fainting spells
__heart palpitations
__chest pain
__shortness of breath/asthma
__fracture or severe injury
__head injury/concussion

Allergies (medication or food) _____ **Reaction**: _____

☐ **Check box if NO KNOWN ALLERGIES**

Preferred Pharmacy (Phone and Fax#): _____

MEDICAL CONDITIONS:

_____

_____

HOSPITALIZATIONS, SURGERIES, EMERGENCY ROOM VISITS (PLEASE INCLUDE DATES)**:**

_____

_____

FAMILY PSYCHIATRIC HISTORY:

_____

_____

DEVELOPMENTAL HISTORY: ☐ History of Child Development Services Referral (CDS)

Temperament during childhood: ☐ Happy ☐ Anxious ☐ Sad ☐ Angry ☐ Other: _____

Fee Schedule & Appointments

At Child & Adolescent Psychiatric Services of Maine, we believe that every individual has a unique personal narrative that shapes how we understand the world and our interactions with those around us. Dr. Kang prefers to devote more time to each patient's case to garner an understanding of the individual's narrative, thereby delivering what we consider to be higher quality health care. Frequency of appointments will be tailored to each patient's specific needs. The expected course of treatment will be discussed at the initial visit.

- Diagnostic Psychiatric Evaluation "Intake - 90792" (90+ minutes) $ 400
- Medication management "60 minute Session - 99215" (40-54 minutes) $ 250
- Medication management "30 minute Session - 99214" (20-40 minutes) $ 150
- Psychotherapy with patient "60 minute Session - 90838" (53+ minutes) $ 250
- Psychotherapy without patient "Family Therapy Session - 90846" $ 250

Payment is due in full at time of service. We accept cash, debit cards, all major credit cards, and personal checks, but note the returned check fee below. We are only **IN NETWORK with ANTHEM OF MAINE, out of state BLUE CROSS/BLUE SHIELD, COMMUNITY HEALTH OPTIONS, CIGNA, some MARTIN'S POINT PLANS, and AETNA.** For other insurance carriers, we will be happy to provide a billing statement for you to submit to your insurance company. ***Please check with your insurance carrier for out-of-network mental health benefits or preauthorization requirements prior to making an appointment to determine your possible reimbursement.***

Appointments are available on Mondays through Fridays. Same day appointments can be accommodated if space is available.

RETURNED CHECK FEE

Checks returned by the bank will be charged a $35 returned check fee.

CANCELLATION POLICY

We understand that situations may arise in which you will not be able to keep an appointment. Should you have to cancel or reschedule an appointment, please give at least one (1) business days' notice. Repeated No-shows or appointments not cancelled with one (1) business day's notice (Short Notice Cancellations) are subject to a $50 charge, at the discretion of CAPS of Maine.

Patients who short notice cancel or fail to show for an appointment 3 or more times in a given 12 month period may be discharged from the practice following a 30 day notice, at your provider's discretion.

Medication and Refill Policy

In order to effectively manage your medication, please be aware that the following guidelines need to be followed:

1. To receive refills of your medication(s), you must make an appointment to see Dr. Kang in person for a 30- or 50-minute session at least every 3-6 months. This minimum frequency tends to vary based on the medication(s) prescribed and stability of the patient.
2. Please notify Dr. Kang or staff at Child & Adolescent Psychiatric Services of Maine immediately of any side effects of your medication.
3. Please notify Dr. Kang or staff at Child & Adolescent Psychiatric Services of Maine any time another physician starts or changes your medication or there is a change in your health status. This is important as certain medications or illnesses can alter the effect of the prescribed medications and adjustments may need to be made.
4. Please anticipate any refill needs and discuss them during the office visit. Refills cannot be done on weekends or holidays.
5. Pharmacies can fax refill requests to 207.303.0023.
6. Requests for refills may take up to 48 hours to be available at your pharmacy.

Limits of Confidentiality

Dr. Kang values and respects the privacy of the patient and considers all therapy sessions to be confidential. Both verbal information and written records about the patient cannot be shared with another party without written consent of the patient or patient's legal guardian. The following are exceptions to this confidentiality as outlined by the American Psychiatric Association:

Duty to Warn and Protect

When there is good reason to believe an individual is threatening serious bodily harm to another person, Dr. Kang is required to warn the intended victim and report this information to the authorities. In cases in which an individual discloses or implies a plan for suicide, Dr. Kang is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults

If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or if a child (or vulnerable adult) discloses abuse or raises concerns that they or another minor (or vulnerable adult) are being abused, Dr. Kang is mandated by law to report this information to the appropriate social service and/or legal authorities.

Minors/Guardianship

Parents or legal guardians of non-emancipated minor patients have the right to access the patients' records. A minor **who is 14 years of age or older** may consent to treatment for abuse of alcohol or drugs or for emotional or psychological problems **and does not need the consent** of a parent or guardian for such treatment. If the parent or guardian consents to such treatment of a minor 14 years of age or older, the minor may not abrogate that consent. If a minor 14 years of age or older consents to such treatment, a parent or guardian may not abrogate that consent. *Sec. 1. 22 MRSA §1502*

Insurance Providers (when applicable)

Insurance companies and other third-party payers are given information that they request regarding services to patients. Information that may be requested includes types of services, dates/times of services, diagnosis, treatment plan, and description of impairment, progress of therapy, case notes, and summaries. ***Please note that since Child & Adolescent Psychiatric Services of Maine is an out- of - network provider (excluding ANTHEM of MAINE, out of state BLUE CROSS/BLUE SHIELD, COMMUNITY HEALTH OPTIONS, CIGNA, some MARTIN'S POINT PLANS, and AETNA), communication with insurance providers will have to be initiated by the patient, and the patient will sign a release of information before any information is given directly to third - party payers.***

Other limits of confidentiality

- In response to a court order, or where otherwise required by law.
- To the extent necessary to make a claim on a delinquent account via a collection agency.
- To the extent necessary for emergency medical care to be rendered.

Notice of Privacy Practices

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.
- We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
- We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.
- You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
- You may have the following rights with respect to your PHI.
- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.

- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective from the date of the signature below, and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Sharon Etzweiler at 207.303.0022, for more information, in person or in writing.

Disclosure of psychotherapy notes.

HIPAA provides special protections to certain medical records know as “Psychotherapy Notes.” All psychotherapy notes recorded on any medium (i.e. paper, electronic) by the physician must be kept by the author and filed separate from the rest of the patient’s medical records to maintain a higher standard of protection. HIPAA defines “Psychotherapy Notes” as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individual’s medical records. Excluded from the “Psychotherapy Notes” definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Written authorization is required by the patient to specifically allow for the release of the Psychotherapy notes to a third party.

I understand I have the right to review Child & Adolescent Psychiatric Services of Maine, PA’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the type of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Child & Adolescent Psychiatric Services of Maine, PA. The Notice of Privacy Practices for Child & Adolescent Psychiatric Services of Maine, PA is also provided on the Child & Adolescent Psychiatric Services of Maine, PA website at www.CAPSofME.com. The Notice of Privacy Practices also describes my rights and the duties of Child & Adolescent Psychiatric Services of Maine, PA with respect to my protected health information. Child & Adolescent Psychiatric Services of Maine, PA reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by accessing the Child & Adolescent Psychiatric Services of Maine, PA website, calling the office and requesting a revised copy be sent by mail, or asking for one at the time of my next appointment. A copy of the current notice will also be posted in the practice.

Patient’s name (parent or legal guardian if patient is under 18)	Date
Signature of patient (parent or legal guardian if patient is under 18)	Date

Patient Consent

Name _____ Date _____

Please initial:

_____ **CONFIDENTIALITY**
I have read and understand the privacy practices for Child & Adolescent Psychiatric Services of Maine, PA. I have received the HIPAA information. If I have any questions at any time, I will bring them to the attention of Dr. Peter Y. Kang.

_____ **LIMITS OF CONFIDENTIALITY**
I agree to the limits of confidentiality and understand their meanings and ramifications. I understand that if I choose to file claims with insurance, Child & Adolescent Psychiatric Services of Maine, PA. will provide necessary information about my services rendered and fees collected.

_____ **CANCELLATION AGREEMENT**
I agree to be financially responsible for missed or cancelled appointments with notice less than 24 hours.

_____ **FEE SCHEDULE**
I agree to and understand the fee schedule for services rendered by Dr. Peter Y. Kang at Child & Adolescent Psychiatric Services of Maine, PA. I acknowledge that the fees incurred for professional services of Dr. Peter Y. Kang at Child & Adolescent Psychiatric Services of Maine, PA are my sole responsibility and payable at the time of service.

_____ **MEDICATION AND REFILL POLICY**
I agree to and understand the medication and refill policy.

_____ **ELECTRONIC MESSAGE/EMAIL AND TELEMEDICINE POLICIES**
I have read and understand the electronic message/email and telemedicine policies, and provided a signature if this is a service I would like to participate in or revoke.

CONSENT TO TREAT

I, _____, have read the policies and procedures of Child & Adolescent Psychiatric Services of Maine and give Dr. Peter Y. Kang consent for evaluation and treatment.

_____ Date _____
Patient signature if 14 years or older

_____ Date _____
Parent/legal guardian if less than 18 years old

_____ Date _____
Treatment provider

Patient Consent to Electronic Message/Email Usage

HIPAA stands for the Health Insurance Portability and Accountability Act. HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.

- When an electronic message/email is sent, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the electric message/email is received by you, someone may be able to access your electronic message/email account and read it.
- Additionally, while we consider your communications private and confidential and do not disseminate information about you without your permission, our email (capsofme@gmail.com) is monitored by Dr. Kang's office manager, who might see the content of your message.
- Email and texting are very popular and convenient ways to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available on the U.S. Department of Health and Human Services website - https://www.govinfo.gov/content/pkg/FR-2013-01-25/pdf/2013-01073.pdf. The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email.
- If you choose to consent to electronic messages/email communication, you should be aware that when we respond to electronic messages/email, we will respond to the address from which it was sent. Employers and on-line services have the right to access and archive electronic messages/e-mail transmitted through their systems. Furthermore, if your electronic messages/e-mail is a family address, other family members may see your messages, therefore, please be aware that you use electronic messages/e-mail at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted electronic messages/e-mail.
- All electronic messages/e-mails between you and your provider regarding symptoms, diagnosis, or treatment will be part of your permanent health information.

I hereby consent to communicate with Child & Adolescent Psychiatric Services of Maine employees regarding my personal health information, services, treatment, and appointments via email. In granting this permission, I have read or have had read to me and understand the information described above. I have had the opportunity to ask questions about this information and all of my questions have been answered. I hereby consent to the appropriate use of email under the terms described above. If I do not wish to participate in this service, please check the corresponding box.

☐ Revocation: I wish to revoke the consent given above with the understanding that my revocation will not affect anyone who takes action in reliance upon this Consent Form without notice of revocation.

Signature of Patient or guardian: _____ Date: _____

CAPS of ME Staff Signature: _____ Date:_____

Telemedicine Consent Form

The purpose of this form is to obtain consent to participate in telemedicine, including, but not limited to video, phone, text, and email.

- There are potential benefits and risks of video-conferencing and other forms of telemedicine that differ from in-person sessions. One of the benefits of telemedicine is that the patient and doctor can engage in services without being in the same physical location. Most research shows that telemedicine is about as effective as in-person treatment; however, there is the possibility of less effective treatment due to the lack of in-person interaction.

- Potential risks of telemedicine include limits to confidentiality. CAPS of ME offers secure video-conferencing services though HIPPA compliant platforms, such as Google Meet and Doxy.me, but there is always the possibility that electronic communications may be compromised. The extent and limits of confidentiality that apply to all treatment at CAPS of ME that are outlined in the CAPS of ME Consent to Treatment apply to telemedicine. Furthermore, there will be no video or audio recordings of the session unless agreed upon by mutual consent. For video-conferencing services, it is important to use a secure internet connection rather than public/free Wi-Fi. It is also important to be in a quiet, private space that is free of distractions (including cell phone or other devices) during the session. If you are not in a private place, there is potential for other people to overhear your sessions. Documentation of telemedicine appointments will be maintained in the same manner as in-person sessions.

- Another possible risk of telemedicine is disruption of service due to technical difficulties. You need to use a webcam or smartphone during video-conferencing sessions. To access the video feed, CAPS of ME will send an email/electronic notification with a hyperlink to access the virtual meeting room at the scheduled start of a session. Please be patient in case there are network or connectivity issues. If, for some reason, we are unable to connect after ~5 minutes, CAPS of ME will call you by phone and discuss what to do next. Please make sure your electronic devices are fully charged before the beginning of a session.

- Telemedicine may not be appropriate at all times or for all people. It may not be appropriate for a person who is currently experiencing a crisis situation requiring high levels of support and intervention. In order to participate in telemedicine, a safety plan with CAPS of ME will be developed that includes at least one emergency contact and the closest emergency room to your location, in the event of a crisis situation. This may also require CAPS of ME contacting third party supports, i.e. 911 or Mobile Crisis Stabilization Unit.

- It is important to be on time. If you need to cancel or change your telemedicine appointment, you must notify your mental health provider in advance by phone or email.

- The same rates apply for telemedicine as in-person appointments. You should confirm with your insurance company that the video-conferencing or other telehealth sessions will be reimbursed; if they are not reimbursed, you are responsible for full payment. Maine law requires parity for payment of in-person and video telemedicine services, but there are some exceptions. Additionally, laws regulating telemedicine may change, resulting in increased or decreased telemedicine coverage.

- As your mental health provider, I may determine that due to certain circumstances, telemedicine is no longer appropriate and that we should resume our sessions in-person.

I have read and understood the information provided above. I have had the opportunity to ask questions about this information and all of my questions have been answered. I hereby consent to participate in telemedicine services under the terms described above. If I do not wish to participate in this service, please check the corresponding box.

☐ Revocation: I wish to revoke the consent given above with the understanding that my revocation will not affect anyone who takes action in reliance upon this Consent Form without notice of revocation.

Signature of Patient or guardian: _____ Date: _____

CAPS of ME Staff Signature: _____ Date:_____

Child & Adolescent
Psychiatric Services of Maine
Peter Y. Kang, DO
Board Certified Child and Adolescent Psychiatrist

Credit/Bank/FSA/HSA Card Recurring Payment Authorization Form

Patient Name: _____ DOB: _____

Credit Card Information	☐ New	☐ Update
Card Type:	☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX	
	☐ Other: _____	

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____/_____ Security Code (CVV #): _____

Cardholder ZIP Code (from credit card billing address): _____

I, _____, authorize *Child & Adolescent Psychiatric Services of Maine* to charge the account above for agreed upon purposes. I understand that the above information will be saved for future transactions and that there is some inherent risk to saving financial information. I agree to not hold *Child & Adolescent Psychiatric Services of Maine* responsible for fraud or theft related to the saving of this information. This Authorization will remain in effect until it is canceled in writing.

☐ By checking this box, I enable *Child & Adolescent Psychiatric Services of Maine* to charge the account for fees and other charges as they accrue.

SIGNATURE _____ DATE _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify *Child & Adolescent Psychiatric Services of Maine* in writing of any changes in my account information or termination of this authorization. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card and will not dispute transactions with my bank or credit card company; so long as the transactions correspond to the terms indicated in this authorization form.