3 Steps for Facility Referrals – Brain Solutions

Step 1

Gather copies of required documents:

- Required for **ALL**
  - Demographic/ Face Sheet
  - Signed *Consent for Treatment* Form* (signed by Patient/ POA/ Guardian and witnessed by staff)
- Required **when applicable**
  - Guardianship or POA paperwork (if documents were signed on patient's behalf)
  - Court Ordered Treatment paperwork
- Required for **all Non-AHCCCS/ ALTCS** payors (i.e. Blue Cross, Cigna, Humana, Aetna, etc.)
  - Insurances card(s) front & back
  - Signed *Financial Agreement* Form (signed by Patient/ POA/ Guardian and witnessed by staff)
- Required for **all consultations**
  - Medical providers orders for the Psychiatric Consult

* Please ensure all necessary paperwork is complete with signatures. **Verbal consents** are accepted in emergency situations to avoid delays with patient care. We ask for your assistance to obtain signatures for verbal consents by getting the necessary forms completed by the responsible party.

Step 2

Scan the documents or save the files to a computer (Accepted files: jpg, tif, png, pdf, doc, docx)

Step 3

Submit the referral using our secure portal:

https://www.brainsolutionscenter.com/referral/

Need copies of our forms visit:

https://www.brainsolutionscenter.com/forms/

Need help or have questions?

Anthony Casias, MA
Behavioral Health Coordinator
Brain Solutions PLLC

Phone: (480) 779-9050 ext 1
Fax: (480) 717-4025
Email: admin@brainsolutionsAZ.com

Patient:_____

DOB:_____ ID:_____

Consent for Evaluation and Treatment

Patient or patient's legal representative agree to the following terms for encounters with Brain Solutions PLLC (BS):

1. **Treatment**: The patient consents to the treatment and services provided by Brain Solutions which may include but are not limited to: psychotherapy, psychiatric services, evaluating patients before prescribing medications, refilling existing prescriptions, regular monitoring of medication use, behavioral healthcare, and any necessary periodic laboratory tests.
2. **Release of Information**: The patient acknowledges and agrees that any health and/or financial information (including information regarding alcohol or drug abuse, HIV related or to other communicable disease related information) may be released to the following:
    a. Healthcare providers or their agents who are providing or have provided healthcare to the patient; any individual or entity responsible for payment of BS's charges; to health care providers or organizations.
    b. All BS staff members, contractors, business associates, service locations, facilities and services and associated staff, and contractors.
    c. Individuals and entities as specified by law, ethical standards, and per insurance billing requirements.
    d. Patients covered under TXIX/TXXI Healthcare benefits waive the right to confidential disclosure with their Primary Care Physician.
3. **Contraband**: Drugs, alcohol, weapons, and other articles specified as contraband by BS may not be brought onto BS Premises. Any illegal substance will be confiscated and turned over to law enforcement authorities.
4. **Dismissal From Provider Services or BS**: Patient may be dismissed from provider care or BS for:
   1. Excessive no-shows/late arrivals, 2. Inappropriate or disruptive behavior, 3. Failure to follow treatment recommendations, 4. Medication dishonesty, 5. Failure to meet financial obligations, 6. Providing false or inadequate information, 7. Failing to authorize the release of records to BS or, 8. Being a difficult patient.
5. **Teaching Program**: BS participates in training programs for therapists and health care personnel. Some patient services may be provided by persons in training, under the supervision and instruction of therapists or other BS providers. These persons in training may also observe care given to the patient by therapists and BS providers and/or contractors. Patient will be notified if treatment is being provided by an unlicensed provider who is directly supervised by a licensed provider. With consent, any observation (e.g. video-taped or audio-taped) by a provider supervisor will be used strictly for educational purposes. Any questions regarding supervision will go to the Clinical Director, Jonathan C. Mackey, LCSW.
6. **Communication**: I understand that BS may: ___Call or ___Text at this number:_____

   Or email:_____

   I authorize the following individuals to inquire and receive verbal information regarding my care.

   _____
7. **Terms of the Agreement**: This agreement shall remain in effect as long as I am seeking services from BS. I acknowledge that I have read, understood and agree to the terms and conditions as outlined in the patient information packet. I may be asked to sign a new agreement every year. This release shall continue for so long as the medical/behavioral health and/or financial records are needed for payment, treatment, or healthcare operations.

I acknowledge receipt of the Notice of Privacy Practices and the Notice of Health Information Practices, this includes information regarding the participation of BS in the statewide Health Information Exchange (HIE), or I previously received this information and decline another copy. I am the patient or the legal representative of the patient and am authorized to act on the patient's behalf to sign this agreement. This includes my email and phone communication preferences.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness (Printed Name/ Signature) Date/Time

Patient:_____

DOB:_____ ID:_____

Financial Agreement

I agree that in return for the services provided to me or the patient (if a different person - hereafter the word 'patient' applies to both) by Brain Solutions PLLC or other affiliates, I will pay the account of the patient and/or make financial arrangements satisfactory to Brain Solutions PLLC. Unless the patient's bill is paid by applicable insurance, government programs or other sources, I agree to pay Brain Solutions PLLC's usual and customary charges. If an account is sent to an attorney for collection, I agree to pay reasonable attorney's fees and collection expenses in addition to the amount due and owing on the bill for medical and behavioral health services rendered to the patient if I am ultimately found to be liable for the bill. I understand and agree that a delinquent account will be subject to interest at the legal rate.

I understand and agree that my insurance and/or the patient's' insurance, if any, will be billed for services rendered to the patient. Payment from the insurer will be sought by Brain Solutions PLLC before I am required to make payment (with the exception of some percentage of co-insurance or co-payment, which I must pay) I understand and agree that I am responsible for knowing my coverage and being transparent with any coverage changes. I further understand and agree that as part of the normal business communication with Brain Solutions PLLC, with regard to this matter, Brain Solutions PLLC staff or representatives may contact me through any of the following methods: letter, email, telephone, text/voice message, or any other available technologies used by businesses for such communications.

If the patient is entitled to any benefits whatsoever, under any policy of health, liability insurance, or from any other party liable to the patient, these benefits are hereby assigned to Brain Solutions PLLC and/or to the providers rendering services for application toward the patient's bill. I authorize the release of any medical and/or account information necessary to process claims/direct payment of benefits from my insurance company and collect payment for services rendered, including any applicable service charges and applicable costs of collections. It is understood and agreed, however, that the patient and I may be contacted using an auto-dialer during collection proceedings.

If you need to cancel or reschedule an appointment, please provide us with at least a 24-hour notice. **If you miss a scheduled appointment without contacting us for cancellation, or cancel with less than a 24-hour notice, our policy is to assess a $100.00* fee payable to Brain Solutions** [unless you and your provider both agree that you were unable to attend due to circumstances beyond your control]. It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus, you will be responsible for the full fee amount as described above. Brain Solutions reserves the right to suspend services until the fee is paid. **Excessive appointment no shows and frequent late arrivals is grounds for discharge from our services.** This includes cancellations without the required 24-hour notice. This cancellation policy is standard in most medical and behavioral health practices and will be strictly enforced.
***Patients covered under TXIX/TXXI healthcare benefits are exempt from paying a fee.**

In the event that the patient has a payment on an active account, whether through cash, check, credit card or other means, and there remain additional funds available after that account is satisfied (e.g. an overpayment), Brain Solutions PLLC is authorized to apply the overpayment to any other account owed by the patient that remains unpaid. Brain Solutions reserves the right to charge a nominal processing fee for all credit card transactions.

I have read, understand, and agree to adhere to Brain Solutions PLLC's Financial Agreement as stated above.

_____ _____

Patient/Authorized Representative Relationship to Patient

_____ _____

Witness Date/Time