Welcome to the Calamity Rose Ranch psychiatry practice intake form

This form is designed to gather essential information to help us understand your needs and provide you with the best care possible. Please fill out the form completely and accurately to ensure we can support you effectively.

If you have any questions or need assistance while filling out the form, feel free to reach out to our office. We're here to help!

Consent for Treatment

I consent to receive mental health services, including psychiatric treatment, from Calamity Rose Ranch for myself and/or my child. My participation is voluntary, and I understand I may terminate services at any time unless court-mandated.

Treatment Plan and Attendance

I will collaborate on an individualized treatment plan and understand that consistent attendance is essential. Frequent no-shows, late cancellations, or failure to follow the treatment plan may

Supervision and Consultation

Providers at Calamity Rose Ranch may consult with supervisors or peers for guidance in result in termination of services.

Payment Policy

Payments are due at the time of the appointment or when insurance processes claims (ERA). Patients may request a payment plan if needed.certain cases, ensuring confidentiality and compliance with HIPAA guidelines.

Emergencies

For urgent concerns, contact your provider through the patient portal or call 563-261-4434. In life-threatening situations, call 911, visit the nearest emergency room, or contact the Eastern Iowa Crisis System (1-844-430-0375 or 988) or the Suicide Hotline (1-800-273-8255).

Client Rights

You have the right to:

- Be treated with dignity and respect.
- Participate in your treatment plan.
- Confidentiality of your records (within legal limits).
- Opt-out of recordings or photos.
- File grievances without fear of retaliation.

Text Message Consent

By signing, I consent to receive appointment reminders via text or email. I understand that

message/data rates may apply, and I can opt-out at any time. I accept the risks associated with unsecured communication formats.

HIPAA Notice

Your Protected Health Information (PHI) is handled in compliance with HIPAA regulations. A detailed HIPAA policy is available on the Calamity Rose Ranch website.

Medication and Refill Policy

- Refill requests may take up to three business days.
- Refill requests must be called in to your pharmacy
- Refills can only be for medications prescribed during appointments
- Some medications require prior authorization. Depending on your insurance, this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.
- Controlled substances require close monitoring and adherence to specific guidelines, which include regular appointments and pharmacy coordination.
- Failure to follow the refill policy may result in termination of services.

Form Requests

If you need any additional forms completed by your provider, please note that there is a $100 fee, and it may take up to 10 business days to process them. A scheduled appointment with your provider is required before any forms can be completed.

Missed Appointments

- New patients: $218 fee for no show
- Established patients: $147 fee for no show
- Late Cancellations: $75 fee for cancellations within 24 hours.
- The office hours are Tuesday-Friday 9am-430pm. Call, text or email through the patient portal are accepted ways of cancellation.

Financial Responsibility Form

Credit Card/ Debit Card Authorization I acknowledge and authorize CALAMITY ROSE RANCH to charge the credit card on file for agreed upon services and agree to pay the amount charges in accordance with my cardholder agreement. I understand that my payment card is stored electronically for future appointments. I acknowledge that my card will be charged at the time of the appointment or when ERAs are received. I agree upon the request to receive billing statements, invoices, and receipts via the mail and or email. If I am an uninsured patient, I authorize payment at time of service. I agree to update any information regarding this credit card account.

NAME, AS IT APPEARS ON CREDIT/DEBIT CARD:

_____

BILLING ADDRESS *including zip code:

_____

Credit or debit card number:

_____

Expiration Date:_____

Verification Code: (3 or 4 digits) _____

If you have any unpaid balances that are unresolved in 3 months of the last charge, the balance will be sent to collections. This charge can include, but not limited to, copays, deductibles, coinsurance and no show/late cancellation fees. By signing this we are given permission to send unpaid balances to collections.

Full Policy Access

A comprehensive version of this consent form, along with related policies, is available on the Calamity Rose Ranch website. If we have an updated version of this form it will be available on the website as well.

Signature: _____

☐ **I will upload insurance card and state issued id to documents in portal or email them to office@calamityroseranch.com before my appointment**