New Patient Policies and Procedures

Thank you for choosing Summit Health and Wellness Center for your mental health needs! Our goal is to provide compassionate and attentive behavioral health and wellness to individuals and their families.

On Your First Visit

Please arrive at least 15 minutes prior to your scheduled appointment time. In the event that you are unable to complete the required paperwork prior to your new patient appointment, please arrive 30 minutes early, in order to complete it in the office. **Please bring the following items to your first appointment:**

- Insurance cards and/ or subscriber information
- Legal ID
- DHS or custody papers
- List of all medications

After Hours

If a NON-EMERGENT matter arises after business hours, please leave a voicemail on the answering machine and you will receive a phone call back during regular business hours. If an EMERGENT/ URGENT matter arises after hours, please attend the nearest emergency room or call 911.

Appointments

Patients are seen by appointments only. Our office hours are Monday through Thursday 8:00 am – 5pm and Friday 8:00 am to 12:00 pm. The office is closed on most major holidays. If you are unable to keep your scheduled appointment, please contact our office at (405) 310- 3735 ext. 1# as soon as possible. Our office requires a **24-hour** notice if an appointment needs to be cancelled or rescheduled. If a 24-hour notice is not provided, a charge will be assessed to the patient of the full amount of the scheduled visit. Summit Health and Wellness Center will make every attempt to provide a reminder of your scheduled appointment, but this does not exempt the patient of a missed appointment fee. Should the patient have 3 no show appointments, they may be dismissed as a patient from our clinic. Likewise, should a patient have frequent cancellations, they may be terminated as a patient from Summit Health and Wellness Center. If the patient is more than 10 minutes late to their scheduled appointment, it will need to be rescheduled and it will be considered a missed appointment.

Closings

In the event we need to close the office early, such as in the event of inclement weather, we will call our patients as far in advance as possible. Should you not be able to attend your scheduled appointment due to weather, it will not be considered a missed appointment. There will be a recorded message on our answering machine and post on social media should we need to close the office for any event. Please follow us on Instagram, Facebook, Twitter, and Yelp!

Prescriptions

Refill requests can be requested by having your pharmacy send a refill request to our office, patient portal, or by calling the office. Please allow 72 hours for medication refills to be processed. Please, call 3 days prior of your medication running out. If you have missed appointments and/ or do not have a follow up scheduled, a refill request may be denied. If we are unable to answer the phone, please leave a detailed voicemail stating the patients full name, date of birth, and prescription needed.

Payment of Services

Payment is due at the time of services. Our providers are on several insurance panels and as a result we will bill your insurance for services rendered. You are responsible for copays, deductibles, co-insurance, and any service your insurance carrier does not cover. It is the patient's responsibility if a referral, form, or authorization is required to be seen in our office prior to their first visit. There will be a $29 fee assessed for any returned checks.

Medical Records

Requests for any medical records must be made in writing. In addition, a HIPAA form must be completed. We ask that you please allow 2 weeks for processing requests for medical records. A fee may be assessed for records requested and will be communicated to the patient once records are requested.

Forms/ Letters

We understand that there are several reasons patients need letters and forms completed by their medical provider. There will be a fee associated with these requests and will be communicated to the patient prior to the form or letter being completed by the provider. Please allow up to 10 business days for all forms/letters to be finalized, depending on the specific requests.

Social Media

The views and opinions that may be expressed on Summit Health and Wellness Center's social media profiles do not necessarily represent our thoughts and opinions and might include the views of others. Any information posted on social media is not to be assumed as medical advice or take the place of care that is being provided by a qualified healthcare provider. Should you submit any content to our social media sites, you understand and acknowledge this information is available to the public and Summit Health and Wellness Center is not responsible for any comments or responses posted. We will not provide any medical advice and/ or treatment recommendations on social media and encourage you to contact your healthcare provider.

Patient Portal

A patient portal is a secure online website that allows patients the convenience of having access to some personal health information. You can access the portal through the website. The patient portal will allow access to the patient's appointment reminders, lab results, medication refill requests, notifications from your Summit Health & Wellness Center and much more.

Acknowledgment and Receipt

I have reviewed the New Patient Policies and Procedures from Summit Health and Wellness Center and am aware that these policies are subject to change at any time.

Signature of patient/ Legal Representative: ____
Description of Legal Representative's Authority: ____
Date: ______________________________

Phone: 405-310-3735
Fax: 405-310-3576
2770 Washington Dr. Suite 100
Norman, OK 73069
summithealthandwellnesscenter.com

Consent for Treatment

I consent to medical and/ or therapy treatment services for myself or the patient/ client for whom I am the parent or legally authorized representative. I understand that Summit Health & Wellness Center will share patient/ client health information according to federal and state law for treatment and operations.

Further, I understand the following information discussed in the appointment is held confidential and will not be shared without written permission except under the following conditions:

- The patient/ client threatens suicide.
- The patient/ client threatens harm to another person(s), including murder, physical harm, or assault.
- The patient/ client reports suspected child abuse, including but not limited to, physical abuse and/ or sexual abuse.
- The patient/ client reports abuse of the elderly.
- The medical provider is required by court order to provide privileged information.
- Based on clinical judgement, the provider may see fit to consult with another clinical and professional provider regarding your treatment.

State law mandates that mental health professionals must report these situations to the appropriate persons and/ or agencies.

Communication between the medical provider and patient/ client will otherwise be deemed confidential as stated under the laws of Oklahoma.

By signing below, I understand the above, and agree to these limits of confidentiality.

Signature of patient/ Legal Representative: ____

Description of Legal Representative's Authority: ____

Date: ______________________________

Patient Authorization for Release of Health Information (PHI)

First Name: ________________________________ Last Name: ______________________________

Date of Birth: ______________________________ Social Security #: __________________________

I request access to the following protected health information from my health record, maintained or created by the provider named below to the recipient named below.

☐ Entire Health Record
(Excludes Billing Records/Notes and Psychotherapy Notes*)
☐ Entire Health Record *
(Includes Billing Records/Notes)
(Excludes Psychotherapy Notes*)
☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain additional records.)
☐ Exchange of Verbal Communication

Or only these portions of my record:
☐ Billing Records
☐ X-ray Reports/Films
☐ Immunization Records
☐ Discharge Summaries
☐ Most Recent Progress Notes
☐ Pathology/Lab Reports
☐ Other ____
____

Release Records From:			Provide Records To:		
Name:			Name:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Fax:	Phone:		Fax:	Phone:	

The information may be disclosed for the following purpose(s): ☐ Continued Treatment ☐ Legal ☐Insurance
☐ At my or my representative's request ☐ Other: ____

I understand that by voluntarily signing this authorization:

- I authorize the use or disclosure of my PHI as described above for the purpose(s) listed.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke this authorization at any time. The revocation must be made in writing to the person/ organization disclosing the information and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I understand that unless the purpose of this authorization is to determine the payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/ or non-communicable disease which may include but is not limited to diseases such as hepatitis, syphilis, gonorrhea, HIV, or AIDS and/ or may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.
- I understand I may change this authorization at any time by writing to the person/ organization disclosing my PHI.
- I understand I cannot restrict information that may have already been shared based on this authorization.
- Information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer be protected by the Privacy Regulation.
- Reproduction of this authorization is as authentic as the original signed authorization.

Unless revoked or otherwise indicated, this authorization's automatic expiration date will be one year from the date of my signature.

I, the undersigned, hereby acknowledge that I have read this authorization to its execution and fully understand the nature of the release.

Signature of patient/ Legal Representative: ______________________________________

Description of Legal Representative's Authority: __________________________________

Date: ____________________________

Credit Card Guarantee for Personal Balance

The credit card guarantee ensures that your account stays up- to- date and current. Your care will be kept on file and only used when payment has not been made by mail or in person. You can make co-pays, pay for special services, or pay your bill with your credit card on file, if you choose. We will charge the amount due if payment has not been made in a timely manner. No show and/ or cancellations not made within 24 hours' notice will be charged to your credit card on file. Any balance that exceeds $200, will be charged for the balance in full.

☐ Uninsured/ Self Pay Patients

I understand that since I do not have insurance that I am personally responsible for payment. I understand that payment is due prior to the services rendered.

☐ Insurance Assignment

I understand that as a courtesy, Summit Health & Wellness Center, will bill my health insurance carriers, but that my bill (remaining balance) is MY responsibility. I understand that Summit Health & Wellness Center will wait up to 90 days for payment from my insurance provider. I understand that any amount owed after insurance has adjudicated a claim for services, which has not been paid by my insurance provider, will be due at the time of remittance has been received from the insurance company and placed on my designated credit card below unless other arrangements have been made and agreed upon in writing. Any insurance payments made on these claims thereafter will be placed on my account as a credit or will be refunded to me, if I so choose.

I understand that if my insurance does not cover the cost of mental health treatment, if my deductible is high, or there are other limitations in my coverage, that I will be responsible for my bill at the time of service.

I agree to the above terms and authorize you to charge any payment not paid by the date due.

Credit Card: ☐ VISA ☐ MASTERCARD ☐ DISCOVER
Card Holder's Name: ______________________________
Card Holder's Billing Address: ______________________________
Card Number: ______________________________ Exp Date: ______/______
Three Digit CID #: ______________

Signature of patient/ Legal Representative: ______________________________
Description of Legal Representative's Authority: ______________________________
Date: ______________________________

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of patient/ Legal Representative: ____

Description of Legal Representative's Authority: ____

Date: ______________________________

Expanded Authorization Option:

Please list any persons you would like to authorize to have access to your billing, appointment or health information* (ex: spouse, caretaker, or other family member):

Name: _________________________________ **Relationship:** _______________________________

Name: _________________________________ **Relationship:** ______________________________

*With the exclusion of information that is protected under State and Federal Law.

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement but was unable to do so as documented below.

Date: ______________ Initials: __________ Reason: ____

Adult Demographics

Patient Information

Patient Name:____
First Middle Last

Preferred Name: ____________________________________ Date of Birth: ________/________/________

SSN: __________-__________-__________ Sex: ☐ Male ☐ Female ☐ Other Race: ______________________

Ethnicity: ______________________ Primary Language: ______________________________________

Address: ______________________________________City: ____________________ State: __________

Zip Code: ____________Cell Phone: (_________)______________ Alt. Phone: (_________)________________

Email: ____ Send Appointment Reminders via: ☐ Text ☐ Call ☐ Both

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer: __________________________________ Employer Phone: (_________)__________________

Occupation: ____________________________ Work Address: _________________________________

Primary Care Provider:__________________ Therapist: ________________ Referred by: __________________

Significant Other Contact Information

Name:____
First Middle Last

Date of Birth: _____/______/_____ SSN: ______-______-_____ Sex: ☐ Male ☐ Female

Address: ______________________________________City: ____________________ State: __________

Cell Phone: (_________)______________ Alt. Phone: (_________)____________________

Employer: _________________________ Occupation: _______________________

Email: ____

Emergency Contact

Primary Contact: ____ Relation to Patient: __________
First Last

Address: ______________________________________City: ____________________ State: __________

Cell Phone: (_________)______________ Alt. Phone: (_________)________________

Secondary Contact: ____ Relation to Patient: __________
First Last

Address: ______________________________________City: ____________________ State: __________

Cell Phone: (_________)______________ Alt. Phone: (_________)________________

I hereby give lifetime authorization for payment of insurance made directly to Summit Health & Wellness Center LLC and any assisting providers, for services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections, and reasonable attorney's fees. I hereby authorize this health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature of Patient/ Guardian: ____

Date: ____

SUMMIT
HEALTH & WELLNESS

Physician-Patient Contract for Marijuana Treatment

General

- This is an agreement between____ and Dr. Smart concerning the
  Patient Name
  use of Marijuana for the treatment of ____.
  Reason for seeking treatment
- I, ____, request treatment of my condition with marijuana. As a result, I
  Patient Name
  expect that I may become more functional and improve my quality of life. I have been treated with other therapies for my condition, which have not provided adequate relief of my symptoms.
- I understand that marijuana is a strong drug and that there is insufficient scientific evidence to confirm its use for clinical purposes. There is also insufficient evidence on the clinical risks and benefits of this drug, including the proper dosage to be used for various medical conditions and symptoms, and the potential interactions between this drug and other medications. As such, I understand my physician may not be knowledgeable about all the risks associated with marijuana use.
- I agree to pay the $200 evaluation fee and understand that this does not guarantee that I will receive a recommendation for treatment with medical marijuana as Dr. Smart will need to evaluate whether this is an appropriate treatment options based on my concerns and medical history.
- I understand that if I miss my scheduled appointment, I will be charged a $100 fee, which will be collected at the time of scheduling. This fee can be applied to a future medical marijuana evaluation appointment if I choose so.

Risks and Side Effects

- I have been informed of the known risks and side effects of taking marijuana including, but not limited to: facial flushing, red eyes, dry mouth, drowsiness, sedation, dizziness, fainting, clumsiness, confusion, fuzzy thinking, impaired attention, impaired concentration, impaired short term memory, agitation, anxiety, paranoia, delusions, hallucinations, amnesia, fast or slow heartbeat.
- When I first start taking marijuana, I may experience the adverse mood reactions noted above. With long term use of marijuana, the effects on attention, concentration and short-term memory may worsen and can persist after I stop using marijuana.
- If I smoke marijuana, I may develop a cough and/or wheeze which may persist with long term use and may result in lung damage.
- I understand that some side effects of marijuana are made worse when used with other medication; for example, drowsiness, sedation and dizziness are worse when marijuana are used with sleeping medication, tranquilizers, pain medications, antihistamines and seizure medications to name a few. I understand it is my responsibility to inform my physician of any and all side effects I have with this medication.
- I understand that if I am pregnant or become pregnant while taking marijuana, my child may acquire behavioral and attention problems as a result of prenatal exposure to marijuana, as well as other unknown complications. It is believed there is also an increased risk of sudden infant death syndrome in babies born to mothers using marijuana in pregnancy.

Authorization

- I agree not to take any pain medications or mind-altering medications other than those approved by my physician Dr. Smart. I will not seek such prescriptions from other physicians without the consent of Dr. Smart.
- I agree to tell any other physician who might treat me that I take marijuana for medical reasons.
- .I agree to tell my physician if I get any new medications prescribed to me by any other physician and if any doses of my current medications are changed by another physician.
- .I agree not to drink alcohol or take other mood-altering drugs (tranquilizers, sleeping pills, other mood stabilizers, etc.) while using marijuana. I understand that using marijuana with other drugs may lead to an overdose.
- I agree to tell my physician all medications I am taking including over the counter drugs, herbs, vitamins, etc.

Legal Implications

- If marijuana causes me to become drowsy, sedated or dizzy, I understand I must not drive a motor vehicle (including all-terrain vehicles, snowmobiles, boats) or operate machinery that could put my life or someone else's life in jeopardy. If I do drive while using marijuana, I can be charged with Impaired Driving. If I am charged with impaired driving, while using marijuana, I agree that Dr. Smart is not to blame and will not be named in any resulting legal action. I accept full responsibility for any and all risks associated with the use of marijuana.
- I agree to keep my marijuana in a safe and secure place, away from children. I will report any stolen marijuana to the police and my physician immediately.
- I agree not to share, sell, lend, trade, transport/ship marijuana or in any way give my marijuana to any other person. I realize this is an illegal act. I also agree that my physician may work with the police to investigate any alleged misuse or sale of my marijuana.
- I give permission to Dr. Smart, and his staff, to verify that I am not seeing other physicians for prescriptions of opioids or other mind-altering medications.
- I agree not to use any illegal drugs with my marijuana, including cocaine, crack, amphetamines (speed, crystal meth, ecstasy) and hallucinogens (LSD, mushrooms, PCP, Ketamine).

Monitoring

- I agree to submit to witnessed urine/saliva or blood specimens at any time that my physician requests and give my permission for them to be tested for alcohol and other drugs.
- I agree to make appointments with my physician, at his/her office in person, at the time of renewal of my medical marijuana treatment.
- I agree to attend all appointments that my doctor makes for me for tests, assessments and treatment with other healthcare workers, such as pharmacists, other doctors, physiotherapists, psychologists, addiction counsellors, etc. I consent to open communication between my doctor and any other healthcare professional involved in my healthcare.
- I agree to a conference with my family or close friend(s), if my physician feels it is necessary and requests it.

Treatment Termination

- I agree to attend all requested follow-up visits with my doctor to monitor my marijuana use and I understand that failure to do so could result in the discontinuation of my marijuana treatment.
- I understand there is a risk of becoming addicted to marijuana. This means I might become psychologically dependent on marijuana, using it to alter my mood or get high. I may be unable to control my use of it. People with a history of alcohol or drug problems are more susceptible to addiction. If this occurs, my marijuana treatment will be discontinued, and I will be referred to a drug treatment program for help with this problem.
- I understand that violent behavior or threats toward my physician, the staff or other patients is illegal and is not allowed. If this happens, my physician may stop recommending medical marijuana to me. I may be asked to leave the office, and the police shall be called. (In addition, my physician may decide to stop providing me medical care altogether.)
- If I violate this agreement, I understand that my physician may discontinue my marijuana treatment (and my physician may decide to stop providing me with medical care altogether.)
- I have read the above agreement and understand it. I have had the opportunity to ask any questions I have regarding medical marijuana and its use, in particular to my health condition. My concerns and questions have been addressed to my satisfaction by my physician.

Patient's signature: ______________________________

Patient Care Coordinator Signature: ______________________________

Physician's signature: ______________________________

Date: ____________________

Medical Marijuana Screening Form

General Information

Patient Name: ______________________________ Date of Birth: ______________

Preferred Name (if any): ______________________________ Gender: ❏ Male ❏ Female

Cell Phone: ______________________________ Email: ______________________________

Home Address: ____________________City: ______________ State: __________ Zip: __________

Reason for seeking medical cannabis:

____

____

Please describe any previous tests or treatments (surgery, injections, medications, therapy, etc.) you have had for the treatment of this/these condition(s): ______________________________

____

____

Previous Medical History

Please note if you have had any of the following medical illnesses/problems:

❏ Psychosis (Personal) ❏ Psychosis (Family History) ❏ Schizophrenia ❏ Anxiety
❏ Bipolar Disorder ❏ Heart Disease ❏ Arrhythmias ❏ High Blood Pressure
❏ Liver Disease ❏ Cerebrovascular Disease ❏ COPD ❏ Emphysema
❏ Other (please list any other diagnoses) ______________________________

____

____

Please list all **CURRENT** medications, including dose and frequency (over the counter, prescription, or supplements): ______

____

____

____

____

Are you pregnant? (females only) ❏ Yes ❏ No ❏ Unsure

Are you willing to undergo regular drug screening and/or pregnancy tests? ❏ Yes ❏ No

Phone: 405-310-3735
Fax: 405-310-3576
2770 Washington Dr. Suite 100
Norman, OK 73069
summithealthandwellnesscenter.com

SUMMIT
HEALTH & WELLNESS

Review of Systems

What symptoms are you currently experiencing?

Constitutional: ❑ Weight loss ❑ Weight gain ❑ Poor appetite ❑ Fatigue ❑ Insomnia ❑ Tiredness

Eyes: ❑ Blurry vision ❑ Eye discharge ❑ Dry eyes ❑ Eye redness ❑ Decrease in vision ❑ Double vision

ENT: ❑ Ear pain ❑ Hearing loss ❑ Tinnitus ❑ Sinus problems ❑ Congestion/ cough ❑ Hoarseness

Cardiovascular: ❑ Chest pains ❑ Palpitations ❑ Rapid heartbeat ❑ Fainting

Respiratory: ❑ Shortness of breath ❑ Cough ❑ Excessive sputum ❑ Difficulty breathing

Gastrointestinal: ❑ Nausea ❑ Vomiting ❑ Diarrhea ☐ Constipation ☐ Reflux

Genitourinary: ☐ Frequent urination ☐ Bed wetting ☐ Urgency ☐ Painful urination ☐ Blood in urine

Musculoskeletal: ☐ Joint pain ☐ Muscle pain/ aches ☐ Weakness ☐ Joint swelling ☐ Leg cramps

Skin: ☐ Rash ☐ Blisters ☐ Itching ☐ Hives ☐ Hair loss ☐ Skin sores ☐ Mole changes

Endocrine: ☐ Heat intolerance ☐ Cold intolerance ☐ Excessive thirst ☐ Excessive sweating

Neurological: ☐ Migraines/ headaches ☐ Dizziness ☐ Tremors ☐ Numbness ☐ Seizures

Allergy/ Immune: ☐ Hay fever ☐ Allergic reactions ☐ Frequent infections ☐ HIV ☐ Hepatitis

Psychiatric: ☐ Anxiety ☐ Depression ☐ Mood swings ☐ Hallucinations ☐ Mania

Substance Use

Tobacco (cigarettes, chew, vape, etc.)

☐ yes ☐ no If yes, amount used per week: ____________________

Duration of use: ____________________ Last Used: ____________________

Alcohol

☐ yes ☐ no If yes, amount used per week: ____________________

Duration of use: ____________________ Last Used: ____________________

Marijuana

☐ yes ☐ no If yes, amount used per week: ____________________

Duration of use: ____________________ Last Used: ____________________

Other Substances (including prescription drug use) ☐ yes ☐ no

If yes, please list all other substances, duration of use, and when last used: ____________________

____

____

____

____

My signature below attests to the fact that I have read and have accurately completed this form to the best of my knowledge. All information regarding my medical conditions and history records I am submitting is completely truthful and represents the medical condition for which I am seeking treatment. I voluntarily consent to this evaluation and understand that I am solely responsible for payment of services.

Patient Signature: ____________________ **Date:** ____________________