Biltmore Medical Associates
147 Asheland Avenue
Asheville, NC 28801
Dr. Samuel B. Thielman

Last Name: _____

First Name: _____

Middle Name or Initial: _____

Date of Birth: _____

Sex: _____

Marital Status: _____

Who referred you to us: _____

Phone Cell # _____

Phone Home # _____

Email Address: _____

Home Address: _____

City: _____

State: _____

Zip: _____

Current Employment: _____

Describe the reason for evaluation: _____

_____

_____

Are you seeking only medication and/or counseling?

_____

Complete back side ➡

Previous psychiatrist hospitalizations and/ or mental health treatment:

_____

Are you currently in crisis? _____

Are you currently having thoughts of harming yourself/ suicide ideation?

_____

Current medications with dosage:

_____

Do your currently have insurance or self-pay:

_____

Primary Insurance:_____

Secondary Insurance: _____

Have you ever experienced any of the following?

Extreme depressed mood	☐yes ☐no	Unexplained losses of time	☐yes☐no
Dramatic mood swings	☐yes ☐no	Unexplained memory lapses	☐yes ☐no
Rapid speech	☐yes ☐no	Alcohol/substance abuse	☐yes ☐no
Extreme anxiety	☐yes ☐no	Frequent body complaints	☐yes ☐no
Panic attacks	☐ yes ☐no	Eating disorder	☐yes ☐no
Phobias	☐ yes ☐no	Body image problems	☐yes ☐no
Sleep disturbances	☐yes ☐ no	Repetitive thoughts (e.g. obsessions)	☐yes ☐no
Hallucinations	☐yes ☐ no	Repetitive behaviors	☐ yes☐no

Have you tried the following? If so, how long and when did you last use?

Methamphetamine	☐yes ☐no	**Family Mental Health History. Check if applicable**	
Cocaine	☐yes ☐no	Alcohol/Substance Abuse	☐yes ☐no
Stimulants (pills)	☐yes ☐no	Anxiety	☐yes ☐no
Heroin	☐yes ☐no	Depression	☐ yes ☐no
LSD/Hallucinogens	☐yes ☐no	Domestic Violence	☐yes ☐no
Marijuana	☐yes ☐no	Eating Disorders	☐yes ☐no
Pain Killers	☐yes ☐no	Obsessive Compulsive Behavior	☐yes ☐no
Methadone	☐yes ☐no	Schizophrenia	☐yes☐no
Tranquilizers/sleeping pills	☐yes ☐no	Suicide Attempts	☐yes ☐no
Ecstasy	☐yes ☐no		
Alcohol. If yes, how much daily?	☐yes ☐no		

Biltmore Medical Associates
147 Asheland Ave
Asheville, North Carolina 28801
Phone: (828) 258-1188 / Fax: (828) 251-1801

BENEFIT CONFIRMATION FORM

Name: of Patient):	Insurance Company:
	Group #:

Please have your insurance card in hand

FORM MUST BE COMPLETED PRIOR TO APPOINTMENT OR THE FULL AMOUNT OF YOUR VISIT WILL BE EXPECTED IN FULL

WHEN YOU CALL YOUR INSURANCE COMPANY ASK THE FOLLOWING QUESTIONS:

"This is (YOUR NAME) and I am calling to get details about my behavioral health benefits."

1. Do I have a co-pay or co-insurance for OUTPATIENT Behavioral Health? _____
2. What is the amount I pay per visit? $ _____
3. What is my deductible? $ _____
4. How much of my deductible has already been met? _____As of Date:_____
5. When does my deductible period start? (Date each year) _____
6. What is the effective date of my insurance policy? (Month/Day/Year) _____
7. How many visits does my policy allow for OUTPATIENT Behavioral Health Per year? _____
8. If I need more outpatient visits what do I do to obtain authorization? _____
9. Is there a yearly maximum for OUTPATIENT Behavioral Health? _____
10. Do I need an authorization for my visits? _____
11. How do I obtain an authorization? _____
12. Where and who should my provider mail claims to? _____
13. What is your EDI Payer number? _____
14. May I please have your name, your extension number and the Reference# for this call?
    Name: (Person Making Call) Date of Call:
    Phone Number called &Time of call:

NOTE: Benefits Confirmation Form should be received by Biltmore medical prior to your first session in order for the office to verify your benefit. This allows our staff to calculate the payment you will be expected to make at the time of service. If this information is not received prior to your visit you will be responsible for the full fee amount until your benefits are verified or this completed form is received. Thank you.

Signature: _____ **Date:**_____

PSYCHIATRIC APPOINTMENT CANCELLATION / NO SHOW POLICY

Cancellation Policy
If for any reason you are unable to attend your scheduled appointment, you must call a minimum of 2-business days in advance. Charges arising from late cancellations or missed appointments without notice are not reimbursed by yours insurance carrier and will not be submitted to your insurer.

Biltmore Medical Associates is pleased to assist you by filing insurance on your behalf. An insurance policy is a contract between you and your insurance company. All deductibles, co-pays, and amounts not covered by your policy are your responsibility and you are asked to keep your account current at each visit. Our providers are participating providers with several insurance plans. However, you are ultimately responsible for payments of all services rendered, including those that are not covered by insurance.

Fee and Unpaid Balances
The fee for your first appointment scheduled will be discussed with you at your initial consultation or prior to your appointment if you wish. After the first visit, charges vary based on the complexity, duration, and treatment rendered during your visit. Physician providers (Psychiatrists) bill services in a manner similar to other physicians – that is a charge for an office visit typically combined with a separate charge for psychotherapy. Telephone and written communications with your provider may be subject to charges based on the duration of the service. Fees for Psychological Testing, Genetic Testing, and certain Consultations to coordinate care will be charged as separate services. We ask that you keep your account current.

Your rights as a Patient/Client
You have the right to ask questions about any procedure during therapy. You have the right to decide at any time to stop seeing your provider and if you wish, your provider will provide you with names of other qualified professionals you might prefer. You have the right to end therapy at any time without moral, legal, or financial obligations other than those already accrued.

Authorization and Consent for Treatment
I hereby grant my authorization and consent to treatment and procedures deemed appropriate and certify that no guarantee or assurance has been made as to the results which may be obtained. I also give my consent for my personal health information to be shared with other clinicians within Biltmore Medical Associates to which I have been referred.

Initial _____ Date _____

Insurance Authorization and Assignment
I hereby authorize Biltmore Medical Associates to release information necessary to process insurance claims and request payment of benefits to be made to Biltmore Medical Associates for services rendered to my dependents or me. I understand that I am responsible for paying any required co-payments and deductibles at the time services are rendered. I hereby authorize my provider and Biltmore Medical Associates to release any information required by my insurance carrier to process insurance claims in the course of my examination or treatment. I authorize payment directly to the billing office of my provider and hereby assign payment for the medical benefits, if any, otherwise payable to me for services.

Initial _____ Date _____

Self-Pay
I have no insurance coverage or I waive the use of insurance. Therefore, I understand that I am responsible for payment at the time services are rendered to me or to my dependents.

Initial _____ Date _____

_____ _____
Signature of Patient or Legal Guardian/Responsible Party Date