Instructions for Sending Referrals to Mokscare Psychiatry and Family Medicine

Thank you for choosing Mokscare Psychiatry and Family Medicine to provide psychiatric services for your residents. To ensure we can process your referrals promptly and effectively, please follow the instructions below.

How to Submit a Referral:

Please submit the completed referral via one of the following methods:

- **Fax**: 505-219-3830
- **Email**: admin@mokscare.com

Required Documentation:

For us to process your referral promptly, ensure that the following documents are included:

1. **Facesheet** – A copy of the patient's demographic information.
2. **Physician Orders** – Any relevant orders from the attending physician.
3. **A copy of the insurance card** – Please include both front and back of the card.
4. **Signed Consent Form** – Include signatures for consent to treatment (attached referral and consent form).

Follow-up:

If you have any questions or need to follow up on a submitted referral, please contact us at **505-504-3276** or email us at **admin@mokscare.com**.

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Mokscare New Patient Referral, Consent and Authorization Form

Referral for Psychiatric Services

Submit referral via one of the following:

FAX: 505-219-3830 / EMAIL: admin@mokscare.com

Facility Name: _____ Facility Phone: _____
Date of Referral: _____ Referring Staff Name: _____ Position: _____
Resident Name: _____ Date of Birth: _____

The following are required to process your referral promptly:

- Facesheet
- Physician Orders
- A copy of Insurance card (front and back)
- Signatures for consent

Reason for Referral Checklist (check all that apply):

☐ Psychotropics - Resident currently on or has past history of psychotropic medication use (medication management)
☐ Psychosocial Status Change (i.e., death of family member, decreased socialization, etc.)
☐ Psychiatric Diagnosis - Past or current history of psychiatric diagnosis and/or hospitalization
☐ Resistance to Care and/or refusal of care or participation in treatment
☐ Mental Status issues/change (please explain below - suicidal ideation, cognition issues, sadness, anxiousness)
☐ Medical Diagnosis that requires adjunctive behavioral care (weight loss secondary to diabetes, chronic pain, etc.)
☐ Behavioral issue (please explain below) Family Issues/Conflict
☐ Adjustment Difficulties to current living environment Discharge Difficulties due to Psychiatric Issues
☐ Adverse Status Change in nutrition, activity participation, vegetative functions, sleep.
☐ Other:

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Treatment Description:

In making this referral, Mokscare is requested and authorized by order of the attending physician to use any necessary diagnostic tools to diagnose and treat the above-named patient as a psychiatric referral (unless otherwise stated). In the case of psychiatric evaluation, treatment might include the prescription of psychotropic medication or if the patient is already receiving psychotropic medication, treatment might include its continuation. The psychiatric consultant will determine whether medication is or remains necessary based upon a thorough evaluation of the patient's past and recent history and behavioral status (corresponding with one or more specific psychiatric diagnosis and targeted symptoms). A determination to prescribe or continue such medication will be further based on careful consideration of the possible benefits/intended outcomes of treatment, possible risks and side effects, alternative forms of treatment, and the possible consequences of not receiving such medication treatment. It is important to understand that the consequences of the use of psychotropic medication cannot always be predicted for any given individual and there is a chance the patient may not react favorably to its administration. It is possible that the medication may need to be changed and/or the dose adjusted over time. It is also important to understand that you can, at any time, withdraw your consent and request that the psychotropic medication be discontinued. A facility representative can contact you and advise you of any new medication treatment or changes to the current medication regimen following the initial evaluation by the provider.

Assignment of Insurance Benefits and Consent to Release Health Information:

The Consenter designated below authorizes Mokscare to release any personal health information pertaining to diagnosis and treatment to any insurance company or third party who undertakes responsibility for Mokscare professional service fees. The Consenter hereby authorizes full payment of the insured portion of the charges to be paid directly to and understands that any portion of the fee not covered by insurance is the responsibility of the patient.

If I have no insurance and/or agree to self-pay treatment, I understand that a Good Faith Estimate will be provided to me where the estimated costs of my treatment are outlined as per the No Surprises Act.

I acknowledge that Mokscare accepts Medicare and Medicaid for covered services and will submit insurance claims on my behalf. If I am covered by Medicaid—either alone or in addition to Medicare—I understand that Mokscare will accept Medicaid's payment as payment-in-full, except for any Medicaid-allowed copayment, coinsurance, or deductible; I will not be personally billed for any balance beyond these amounts.

I understand that Medicare may adjust its allowable rates and supplemental policies (including Medigap plans) may not cover the entire balance. If I do not have Medicaid or other supplemental coverage to fully satisfy the balance (including Medicare cost-sharing), I am financially responsible for any remaining amount after insurance has been paid.

If Mokscare is not in-network with my Medicare or supplemental plan, I understand that insurance may pay only in part or pay me directly. Any payment I receive for services rendered by Mokscare must be promptly forwarded to Mokscare.

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Mokscare is committed to affordable care. If I have a deductible, coinsurance, or copay owed after insurance, Mokscare may offer to establish a monthly payment plan. I also understand that under New Mexico law, Mokscare will screen for possible financial assistance if I am at or below 200% of the federal poverty level and will provide clear, plain-language bills that detail dates, charges, and efforts to obtain payment from insurance before seeking any collection action.

I authorize Mokscare to consult with and discuss the results of my confidential evaluation and treatment with the medical, nursing, and therapeutic staff in order to facilitate the highest level of medical restoration and quality of life.

Statement of Consent:

I consent to psychiatric services to be provided by Mokscare Psychiatry & Family Medicine. If I reside in a facility that service provision is through telemedicine technology, I consent to services. I understand that Mokscare only provides psychiatric services to clients and will not engage in any personal relationship with clients and their families outside of professional relationships. I understand my evaluations and treatment are confidential, but there are limits to confidentiality.

Confidential information may be disclosed under the following conditions:

- *I have been evaluated to be a danger to myself or others*
- *My treating clinician believes I am the victim of abuse or if I divulge information about such abuse*
- *I give consent to disclose information*

☐ **I DO CONSENT** to the treatment designated herein, including necessary recommended psychotropic medication treatment other than _____(no exclusion unless specified). I give consent voluntarily and without coercive or undue influence. I understand this consent may be revoked at any time.

☐ **I DO NOT CONSENT** to the treatment designated herein.

_____ _____

Resident's Name (Print) Resident's Signature & Date

_____ _____

Resident's Authorized Representative's Signature & Date Relationship to Patient

Telephone/Verbal Consent if Patient/Responsible Party Unavailable to Sign

Name of Person Giving Consent _____ Relationship to Resident _____

_____ _____

Name of the Person Who Obtained Consent/Completed Form Signature

Title _____