PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #:_____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE:_____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY:_____

MARITAL STATUS: ☐SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT:_____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)
_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP:_____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY:_____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP:_____

BUSINESS PHONE # : _____

`

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT
By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ Date: _____

12388 Warwick Blvd. Ste. 303
Newport News, VA. 23606

PATIENT NAME: _____ DOB: _____ SSN#: _____

RACE: _____ PHONE#_____ PHARMACY NAME_____

Your email address _____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any questions, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important.

Who referred you to Available Mental Health Services _____

What is your chief complaint?

_____

_____

ALLERGIES

List anything that you are allergic to (medications, food, bee stings, etc.) and how each affects you.

ALLERGY	REACTION

MEDICATIONS

Please list all the medications you are taking. Include prescribed and over-the-counter drugs (vitamins and inhalers).

DRUG NAME	STRENGTH (MG)	HOW MANY TIMES DAILY

PATIENT NAME: _____

12388 Warwick Blvd. Ste. 303
Newport News, VA. 23606

Past Medical History (Please check all that apply)

Head Trauma		Incontinence		Goiter	
Blindness		Nephrolithiasis		Hypothyroidism	
Cataracts		Other kidney disease		Thyroid disease	
Glaucoma		UTis		Type I Diabetes	
Wear glasses/contacts		Fibromyalgia		Anemia	
Wear hearing aids		Arthritis		Cancer	
Dentures		Gout		HIV	
Allergic rhinitis		Dermatitis		STDs	
Sinus infections		Moles		Tuberculosis	
Aneurysm		Other skin conditions		Gallbladder disease	
DVT (Blood Clots)		Psoriasis		Hernia	
High Cholesterol		Epilepsy		Hepatitis	
HTN (High blood pressure)		Seizures		Jaundice	
Heart attack		Severe headaches, migraines		Cirrhosis	
Heart Murmur		Stroke		GERD (heartburn)	
Other heart Disease		TIA		Ulcer	
Asthma		Bipolar Disorder		Anxiety	
Bronchitis		Depression		Hallucinations	
COPD (Congestive Heart Disease)		Delusions		Suicidal ideation	
Bronchitis//Emphysema		Suicide attempts			

Past Psychiatric History:

Prior Psych Dx: _____

_____

Past Psych Meds Used_____

Hospitalizations for psychiatric reasons? Yes, No When? _____

Outpatient Treatment? Yes, No Where? _____

Sleep Difficulties? Yes No

Past Surgical History:

PATIENT NAME: _____

Available Mental Health Services
12388 Warwick Blvd. Ste. 303
Newport News, VA. 23606

Family History:

Please indicate any that apply to your family history including father, mother, maternal and paternal grandparents, brother(s), and sisters (s).

Disease	Who (father, mother, etc.)
Arthritis	
Asthma	
Bleeding Disorders	
Coronary Artery Disease	
COPD	
Diabetes	
Heart Attack	
Heart Disease	
High Cholesterol	
Hypertension	
Mental Illness	
Osteoporosis	
Stroke	
Breast Cancer	
Colon Cancer	
Ovarian Cancer	
Prostate Cancer	
Uterine Cancer	
Other Cancer	

Social History:

Education	Alcohol	Tobacco
Less than High School	Do not drink	Do not smoke
High School	Drink daily	Former smoker
College	Frequently drink	Heavy smoker
	Occasionally drink	Light smoker
	History of Alcoholism	

Drugs:

Do you currently use recreational or street drugs?

Yes, No If yes please list: _____

_____

PATIENT NAME (PRINT)_____

PATIENT SIGNATURE: _____DATE: _____

AVAILABLE MENTAL HEALTH SERVICES

CONSENT TO TREAT/ASSIGNMENT OF BENEFIT AUTHORIZATION
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
Telephone: (757) 223-7810

Patient Name: _____ Date: _____

Consent for Mental Health Treatment

I authorize the healthcare providers of **Available Mental Health Services** to administer treatment as deemed necessary for care of the patient named above. This pertain to today's visit and any future visits involving treatment by the healthcare provider of **Available Mental Health Services**. I certify that I am the patient or legal representative of stated patient. I also certify that no guarantee or assurance has been made as to the results that may be obtained from the treatment.

Confidentiality

Under most circumstances, the communications between a provider and a client is held confidential. In the case of: (1) danger to self or others, (2) a valid court subpoena, or (3) existing or suspected abuse (physical, mental, financial, or sexual); your therapist is required to waive confidentiality and take specific actions.

Assignment of Benefits

All professional services rendered are charged to the patient. As a service to the patient, necessary forms will be completed to help expedite insurance carrier payments. The patient/legal representative is responsible for any unpaid balances. Co-payments will be made at the time of service. I request that payment of authorized Medicare, Medicaid or other insurance company benefits be made to **Available Mental Health Services** for any services furnished to me by the provider at **Available Mental Health Services**. All regulations pertaining to Medicare and Medicaid assignment of benefits apply. I authorize any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for related services.

Notice of Privacy Practices

In April 2003, new federal requirements regarding privacy of information for health care patients take effect. H.I.P.A.A., the **Health Insurance Portability and Protection Act** requires that all medical providers, insurance companies, and others, put in place controls to ensure that your personal medical information is safe.

Available Mental Health Services requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Our **Notice of Privacy Practices** provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this document.

Telemedicine for Established Patients

I understand that some patients may quality, after initial evaluation, for Telemedicine as an alternative to an office visit. For those who qualify, additional consent must be obtained. More information is available upon request.

Patient Name: _____ Patient signature: _____
(Print Name here) (Sign here)

Legal Representative Name: _____ Signature: _____
(Print Name here) (Sign here)

Please check appropriate box:

☐ Responsible Party ☐ POA ☐ Guardian ☐ Attorney

AVAILABLE MENTAL HEALTH SERVICES
EXPLANATION OF BILLING POLICY

Date of Birth: _____

Responsible Party (if different from person receiving services) _____

Name of Responsible Party: _____

Relationship: _____

Billing Address: _____

City/State/Zip: _____

ASSURANCE AND AUTHORIZATIONS TO RELEASE CONFIDENTIAL INFORMATION

I authorize payment directly to AMHS for any benefits to which I am entitled. I further authorize the release of information to third parties for the purpose of obtaining payment for services.

I understand that, in order to protect the confidentiality of information, AMHS will not discuss my account with anyone to who I have not authorized release of confidential information. I authorize AMHS to discuss any financial or billing issues concerning my account with the following persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that payment is expected at the time of service.

I understand that some services may not be covered by insurance.

I understand that I am expected to notify AMHS of any change with regard to insurance coverage and under my billing contact information.

I authorize the release of information to any court, legal, collection, or credit organization of their agents for the purpose of obtaining payment for services.

I understand that AMHS reserves the right to use established collection procedures including submission of any overdue balance to the Virginia Department of Taxation for collection through the Debt Set-Off Collection Program if I fail to pay for services received from AMHS. I authorize the release of information to the Virginia Department of Taxation or its agents for the purpose of obtaining payment for services.

I understand that I am required to pay the amount assigned by my insurer for each service received. If I elect to not provide AMHS with insurance information or authorization to disclose information for payment, I understand that I am responsible for paying the full fee.

I understand that I have the right to revoke this authorization subsequent to paying my account balance in full. I understand that I will be responsible for paying the remaining balance.

Signature of the individual/responsible party:

_____ _____

NAME DATE

AVAILABLE MENTAL HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES AND PROTECTED HEALTH INFORMATION
[*45 CFR 164.520*]

Background

The HIPAA Privacy Rule gives individuals a fundamental new right to be informed of the privacy practices of their health plans and of most of their health care providers, as well as to be informed of their privacy rights with respect to their personal health information. Health plans and covered health care providers are required to develop and distribute a notice that provides a clear explanation of these rights and practices. The notice is intended to focus individuals on privacy issues and concerns, and to prompt them to have discussions with their health plans and health care providers and exercise their rights.

How the Rule Works

General Rule. The Privacy Rule provides that an individual has a right to adequate notice of how a covered entity may use and disclose protected health information about the individual, as well as his or her rights and the covered entity's obligations with respect to that information. Most covered entities must develop and provide individuals with this notice of their privacy practices.

The Privacy Rule does not require the following covered entities to develop a notice:

- Health care clearinghouses, if the only protected health information they create or receive is as a business associate of another covered entity. See 45 CFR 154.500(b)(1).
- A correctional institution that is a covered entity (e.g., that has a covered health care provider component).
- A group health plan that provides benefits only through one or more contacts of insurance with health insurance issuers or HMOs, and that does not create or receive protected health information other than summary health information or enrollment or disenrollment information.

See 45 CFR 164.520(a).

Content of the Notice. Covered entities are required to provide a notice in plain language that describes:

- How the covered entity may use and disclose protected health information about an individual.
- The individual's rights with respect to the information and how the individual may exercise these rights, including how the individual may complaint to the covered entity.
- The covered entity's legal duties with respect to the information, including a statement that the covered entity is required by law to maintain the privacy of protected health information.
- Whom individuals can contact for further information about the covered entity's privacy policies.

The notice must include an effective date. See 45 CFR 164.520(b) for the specific requirements for developing the content of the notice.

A covered entity is required to promptly revise and distribute its notice whenever it makes material changes to any of its privacy practices. See 45 CFR 164.520(b)(3), 164.520(c)(1)(i)(C) for health plans, and 164.520(c)(2)(iv) for covered health care providers with direct treatment relationships with individuals.

Providing the Notice.

- A covered entity must make its notice available to any person who asks for it.

- A covered entity must prominently post and make available its notice on any web site it maintains that provides information about its customer services or benefits.

- *Health Plans* must also:

  - Provide the notice to individuals then covered by the plan no later than April 14, 2003 (April 14, 2004 for small health plans) and to new enrollees at the time of enrollment.
  - Provide a revised notice to individuals then covered by the plan within 60 days of a material revision.
  - Notify individuals then covered by the plan of the availability of and how to obtain the notice at least once every three years.

- *Covered Direct Treatment Providers* must also:

  - Provide the notice to the individual no later than the date of first service delivery (after the April 14, 2003 compliance date of the privacy Rule) and, except in an emergency treatment situation, make a good faith effort to obtain the individual's written acknowledgment of receipt of the notice. If an acknowledgment cannot be obtained, the provider must document his or her efforts to obtain the acknowledgment and the reason why it was not obtained.
  - When first service delivery to an individual is provided over the Internet, through email, or otherwise electronically, the provider must send an electronic notice automatically and contemporaneously in response to the individual's first request for service. The provider must make a good faith effort to obtain a return receipt or other transmission from the individual in response to receiving the notice.
  - In an emergency treatment situation, provide the notice as soon as it is reasonably practicable to do so after the emergency situation has ended. In these situations, providers are not required to make a good faith effort to obtain a written acknowledgment from individuals.
  - Make the latest notice (i.e., the one that reflects any changes in privacy policies) available at the provider's office or facility for individuals to request to take with them and post it in a clear and prominent location at the facility.

- A covered entity may email the notice to an individual if the individual agrees to receive an electronic notice.

See 45 CFR 164.520(c) for the specific requirements for providing the notice.

Organizational Options.

- Any covered entity, including a hybrid entity or an affiliated covered entity, may choose to develop more than one notice, such as when an entity performs different types of covered functions (i.e., the functions that make it a health plan, a health care provider, or a health care clearing house) and there are variations in its privacy practices among these covered functions. Covered entities are encouraged to provide individuals with the most specific notice possible.

- Covered entities that participate in an organized health care arrangement may choose to produce a single, joint notice if certain requirements are met. For example, the joint notice must describe the covered entities and the service delivery sites to which it applies. If any one of the participating covered entities provides the joint notice to an individua, the notice distribution requirement with respect to that individual is met for all of the covered entities. See 45 CFR 164.520(d).

Date: _____

At Available Mental Health Services (AMHS), our goal is to provide quality mental health care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients. The following policy is regarding patients who fail to keep their scheduled office visit appointment.

Please be courteous and call the clinic promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to a timely visit.

- Patients who fail to show for their scheduled appointment or did not notify the office within the 24 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation” fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.
- Patients who fail to show up for their scheduled office visit twice without notifying the office within 24 hours of their scheduled appointment time, shall be subject to a “No Show/Cancellation fee of $150.00, that must be made prior to making another appointment.
- If you are cancelled by the clinic then you are not subject to this charge **These fees are not covered by insurance and is therefore the sole responsibility of the patient.**

HOW TO CANCEL YOUR APPOINTMENT

To cancel or reschedule appointments call AMHS at 757-223-7810. If you have any problems getting through, you can leave a message with your name, appointment date and time, cancellation reason or request for rescheduling.

_____ _____
Patient Signature Date

_____ _____
Printed Name Date

_____ _____
Witness Signature Date

PRESCRIPTIONS FOR BENZODIAZAPINES AND STIMULANT MEDICATIONS

The goal of Available Mental Health Services medication prescribers is to recommend and prescribe medications for optimal clinical benefit and minimal risk. Since there are other options available to treat several psychiatric conditions, each individual and family member is encouraged to discuss it with the provider.

There are medications approved by the FDA which are safer for long term treatment as well as various modalities of therapy in conjunction with or without medication.

If you are taking a Benzodiazepine daily you are encouraged to discuss treatment options with your prescriber on your next visit. Evidence has shown that there is a risk of tolerance and dependency along with the knowledge of the tremendous risk from the increasing overuse of these medications. The prescribers at AMHS will not be prescribing such medication for continuous use.

Stimulant medications may be prescribed only to individuals involved in academic and or work-related activities that present with ADHD test results that are current within the past 3 years.

_____ _____

Patient Signature Date