NORTH ALABAMA
FAMILY PSYCHIATRY
&
COUNSELING

PATIENT REGISTRATION FORM

Patient Information

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____Work #: _____

Employer: _____ Social Security #: _____

Birth Date: _____ Age: _____ Gender: _____ Marital Status: _____

EMERGENCY CONTACT: NAME _____ **PHONE:** _____

Legal Guardian Information (If patient is less than 18 years old)

Legal Guardian Name: _____ Relationship to Patient: _____

Home #: _____ Cell #: _____Work #: _____

Responsible Party Information

Responsible Party is Patient: ☐ Yes ☐ No Relationship to Patient: _____

First Name: _____ Last Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Cell #: _____Work #: _____

Financial and Policy Holder Information

Primary Insurance
Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐ M or ☐ F

Secondary Insurance
Insurance Company: _____ Contract #: _____ Group #: _____

Effective Date: _____ Policy Holder Name: _____

Policy Holder SS#: _____ Birth Date: _____ Relationship to Patient: _____

Policy Holder Address: _____ City, State & Zip: _____

Policy Holder Phone #: _____ Sex: ☐ M or ☐ F

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NALFPC
PRIVACY OF PROTECTED HEALTH INFORMATION

I consent to the use of disclosure of my protected health information by North Alabama Family Psychiatry & Counseling (hereinafter referred to as "NALFPC") for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct healthcare operations of NALFPC.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. NALFPC is not required to agree to the restrictions that I may request. However, if NALFPC agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that NALFPC has taken action in reliance on this consent.

My protected health information means health information, including my demographic information collected from me and created or received by my physician, another healthcare provider, health plan, my employer, or a healthcare clearinghouse. This protected health information relates to my past, present, and future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review NALFPC's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of NALFPC. The Notice of Privacy Practices also describes my rights and NALFPC's duties with respect to my protected health information.

If you have asked us to file health insurance for you, we send only the minimum information required to obtain payment from your insurance company. We do not release any information to anyone about your treatment nor do we acknowledge that you are a patient here (even to your immediate family or other healthcare providers) without your expressed written consent. If you wish us to communicate with anyone about your treatment, please ask for a release of information form.

NALFPC reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent by email or asking for one at the time of my appointment.

Initial _____

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EXCEPTION TO PRIVACY, PRIVILEGED COMMUNICATIONS AND CONFIDENTIALITY

Any unusual circumstances information that the client discloses may be released without consent to the appropriate parties involved if:

- There exists a danger of harm to the client or someone else
- The client needs to be involuntarily hospitalized due to the debilitating effects of mental illness or substance abuse
- The client is required to undergo a court-ordered examination
- The client discloses information about abuse, neglect, or exploitation of a minor
- The client discloses information about abuse, neglect, or exploitation of an aged or disabled adult
- The client's mental or emotional condition is used as a legal defense
- A civil, criminal, or disciplinary action arises from a complaint filed on behalf of the client against a mental health professional in which case the disclosure and release of information shall be limited to that action

I hereby give my consent for service to be provided under these conditions.

NALFPC
INFORMED CONSENT FOR TREATMENT

- I understand the concepts and conditions of informed consent, privacy and confidentiality.
- I understand that I have the opportunity to discuss these concepts and conditions and to ask for clarification of parts which I am concerned about or do not fully understand.
- I understand that I will be informed of the goals, expectations, procedures, benefits, and possible risks involved in the evaluation and counseling/treatment.
- I understand that the process of counseling, psychotherapy, and evaluation is an interview process requiring self-disclosure, self-exploration, and responsible action. It has the overall purpose of promoting understanding and change. Sometimes this process can be stressful and emotionally uncomfortable. At other times, it can be very fulfilling. I also understand that there are no guarantees of positive outcome for the therapy/treatment.
- I have the right to refuse or withdraw from any counseling, psychotherapy, or evaluation procedure unless otherwise specified by law.
- I have the right to question any procedure, intervention, rationale, or discussion that is unclear or that I do not understand.
- I understand that all communication will be private, legally privileged, and confidential unless otherwise specified by the specific laws presented below or unless I provide my written consent with a specified release of information. I understand that if my provider is a resident or inter, then the treatment will be discussed with a supervising professional.
- I understand that this consent may be withdrawn by me at any time without prejudice and has to be completed in writing.

Initial _____

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NALFPC
FINANCIAL AND PAYMENT POLICIES

Our policy is full payment at the time services are rendered. We accept Cash, Check, Visa, Discover, and Master Card. There will be a **$75** service charge for each returned check.

We require a **24 Hour notice for cancellation**. We will attempt to make a reminder call or text the business day before your appointment as a courtesy, however you are responsible for keeping up with all appointments.

_____ For ***late*** cancellations **you will be charged $60**.
(Initials)

_____ For ***No Shows*** **you will be charged $60**.
(Initials)

Non-Urgent calls to the after hour On Call service will accrue a **charge of $25.** You may leave a voicemail on our line or call during business hours for all prescription refill request or appointment change/cancellation request.

Your insurance card(s) may be copied each time you are seen. We must verify correct insurance information at each visit.

Benefits quoted by your insurance company are NOT a guarantee of payment. **You will be asked to pay any charges not paid by your insurance company.**

We bill your insurance as a courtesy. If you disagree with any amount your insurance pays or they do not pay, you are responsible for the terms of that agreement.

Your insurance contract is an agreement between you and the insurance company and as the subscriber, you are responsible for the terms of that agreement.

You are responsible for confirming with your insurance company that the providers you are seeing are in your network.

You may be billed for letters or forms completed by your provider. Fees vary.

You will be billed **$25 for lost prescriptions** and **$5.00 for prescriptions that have to be mailed.**

We will gladly file your primary and secondary insurance for you.

It is understood that, regardless of amounts reimbursed by your insurance company, you as the patient/responsible party will be responsible for full amounts charged. If your account is turned over to an attorney or collection agency for nonpayment, you will also be responsible for additional attorney or collection fees. If you are covered by managed care you may be exempt from payment of charges not fully covered by your insurance.

I authorize NALFPC to file insurance for me and to provide the insurance company any information necessary. I further authorize payment to be made directly to my provider at NALFPC.

I have read and understand the policies above and agree to abide by them. I understand that I am financially responsible for payment for all services at the time services are rendered. I agree to be liable for any costs incurred in the collection of any unpaid balance, including any and all reasonable attorney fees.

I authorize my provider at NALFPC to release any medical and/or psychiatric information acquired in the course of my examination or treatment to my health insurance company to facilitate payment for medical services rendered. I authorize payment of medical benefits to my provider at NALFPC.

Initial _____

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AUTHORIZATION FOR CONTACTING PATIENT

Should a circumstance arise when it becomes necessary for the office to call you for any reason (such as to verify or change your appointment), every effort will be made to notify you in a timely manner. Please indicate your preference for being contacted.

1. Telephone my home	☐ Yes ☐ No	home # _____
2. Telephone my place of employment	☐ Yes ☐ No	work # _____
3. Email Contact	☐ Yes ☐ No	email _____
4. Text message	☐ Yes ☐ No	cell # _____
	Cell Phone Carrier	_____

After 3 unsuccessful attempts to contact you in the manner indicated above, we will write a letter addressed to you asking that you contact the doctor's office.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

INFORMATION FOR CLIENTS

Our Practice

We are a group of licensed mental health professionals in private practice. Our office is open Monday through Friday from 8:00 AM to 5:00 PM. We see clients by appointment only. Appointments are scheduled according to the individual doctor/therapist recommendation. If there is an emergency during office hours, which requires immediate attention, please contact the office by phone.

If an appointment cannot be kept, please contact the receptionist at least 24 hours in advance. There will be a ***$60 service charge for late cancellations and a $60 service charge for no shows***.

Confidentiality

Communications between the provider and the patient are strictly confidential and protected under Alabama Law and by the ethics of our profession. In order to communicate with others about your case, your provider must have permission in writing. Our registration form and our Notice of Privacy Practices explain the limits of confidentiality.

After Hour Emergencies

Our telephone number is **256-724-8880**. If you need to speak with your doctor or therapist, please make your calls brief. Calls of more than 5 minutes will be billed at the provider's hourly rate. Calls are answered 24 hours each day, 7 days a week. After office hours, you can leave a message on the voice mail or in an urgent situation; leave a message with the answering service operator who will contact your doctor/therapist/provider or the person on call. **Non-Urgent calls will accrue a charge of $25.** You may leave a voicemail or call during business hours for all prescription refill request or appointment change/cancellation request. **If immediate services are required or you have an emergency, please call 911 or go to the nearest Emergency Department.**

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PATIENT RIGHTS AND RESPONSIBILITIES

Patients have the right to:

- Be treated with respect and dignity.
- Have their cultural, psychosocial, spiritual, and personal values, beliefs, and preferences respected.
- Receive quality treatment from trained individuals, regardless of race, creed, sex, or national origin.
- Receive treatment in the least restrictive environment.
- Be informed about their diagnosis, treatment, prognosis, and any recommended treatments in terms that they can understand.
- Make informed decisions regarding their treatment.
- Refuse treatment.
- Receive treatment in an environment that is safe and secure.
- Privacy and confidentiality.
- Access information contained in their medical record, according to federal privacy laws, unless clinically contraindicated.
- Be informed of any rules and regulations governing NALFPC, which affect them.
- Access the Quality Improvement Officer to voice and receive aide in resolving concerns, conflicts, grievances, and/or complaints.
- File a complaint with the appropriate state regulatory agency.

Patients are responsible to:

- Inform their network provider to the best of their knowledge, complete and accurate information regarding their medical history, including present symptoms, past illnesses, medications, both prescription and non-prescription, hospitalizations, etc., and to report any changes in their health or in the medication they take.
- Accept consequences should they refuse treatment or not follow the recommendations of the treating professional.
- Ask questions of their network provider, or as applicable, NALFPC staff when they are unclear about any aspect of their treatment.
- Protect the confidentiality of other patients by not disclosing their names or any other information disclosed by other patients.
- Be considerate of the rights of other patients and staff.
- Take an active part in planning, implementing, and following through with their treatment program.
- Provide adequate notice in the event they are unable to attend a scheduled appointment.
- Notify their network provider if they choose to discontinue their treatment.
- Follow the rules of the program in which they are participating.
- Meet financial commitments agreed to with their network provider.

ACKNOWLEDGEMENT OF RECIEPT

Your signature acknowledges that you have received a copy of the Patient Rights & Responsibilities.

Patient Name: _____

Patient Signature: _____

Date Signed: _____

Patient Representative (if applicable): _____

Relationship of Representative (if applicable): _____