North Wind Behavioral Health
New Client Information

Date: ______________________ Social Security #: _________/_________/_________

Name: ________________________________ Birth date: ____________ Age: _____ Sex: _____ Race: ____________

Home Phone: ____________________ Cell phone: ____________________ Email: ____________________

Mailing Address: ________________________________ City / Village: ____________ State: ____ Zip: ______

Occupation: ____________________ Employer: ____________________

Education (circle last year completed): 4 5 6 7 8 9 10 11 12 College/Tech: 1 2 3 4 Graduate: 1 2 3 Degree:____________

Military History: List branch of service and years________________________Served in combat?____________

In case of emergency—List next of kin: ________________________Telephone: ____________

How did you hear about us? Clergy _____, Physician _____, Another client _____, Friend or family _____, Media _____, Legal _____, Insurance ___, Social service agency ___, School ___, other (please name) ____________________

Marital Status: _____ Single (never married); _____Engaged; _____Living with; ____ Married; ____Widow; ____ Separated: _____ Divorced

Spouse/Partner's Name: ________________________________

Address: ____________________ City/Village: ____________ State: ________ Zip: ________

Birth Date: ________ Age: _____ Education: ____________ Occupation: ____________

Employer:________________________ Date of this marriage: ____________

We subscribe to an Appointment Notification Service. How would you like to be notified of your upcoming appointment?

_____Email ____ Call to Home/Cell (Circle one) _____Text message to Cell ____ Do not notify me

Religious affiliation: Present ____________ Past ____________ Congregation you attend ____________

How would you rate your spiritual life (10 great – 1 poor) Why? ____________________

Check and comment about the following as they apply to you:

______ Current/chronic medical conditions ____________________

______ Serious illnesses/injuries/traumas ____________________

______ Hospitalizations or surgeries ____________________

Physician ____________________ Date of last exam ____________

Allergies ________________________________

List current medications,	Dosage	Who prescribes?

Preferred Pharmacy ________________________________

Herbal Supplements ________________________________

Have you ever had counseling? ____Yes ____ No When and Where? ____________________

Acknowledgment Form

May we contact the professional person or organization who referred you? Circle Yes No
If Yes, Please list name, phone number and address: ______________________________

____

TELEPHONE PRIVACY: *Please answer the questions below.*
(H) May we call Yes or No May we leave messages? Yes or No
(C): May we call Yes or No May we leave messages? Yes or No
(W): May we call Yes or No May we leave messages? Yes or No

Home# ____________________ Work# ____________________ Cell # ____________________

GENERAL CONSENT TO COUNSELING

I consent to begin counseling, including evaluation, treatment or referral. I agree to pay for counseling services including medical, psychological or psychiatric consultation fees and testing charges. All clients will be charged the therapist's standard fee for cancellations made with less than 24 hour notice or for failure to show for an appointment. Note: This charge is not covered by insurance. Unforeseen emergency situations will be taken into account.

I have read the *Informed Consent for Counseling and our Fee Policy Agreement*, the *Notice of Privacy Practices* and I understand and agree to the policy described herein. I have also read the *Disclosure Statement* which documents my counselor's degree(s), credentials and license(s). A copy of these documents has been given to me for my records.

I agree to pay as services are rendered in the following manner:

- ☐ I will pay the contracted fee at each visit.
- ☐ I will pay the co-payment as required by my insurance company, managed care agency or HMO

I acknowledge that I have given my correct and complete insurance information below. I understand that if I have given incomplete or incorrect information that I will be responsible to pay for services.
Please fill out both primary and secondary insurance information below: *Please write neatly.*

Primary Insurance Information:

Name of Insurance Co.:______________________________

Name of Insured Person:______________________________

Primary Insurance ID#: ______________________________

Insured's SSN: ________-_______-___________

Relationship to Insured: Self/Spouse/Parent/Guardian/Other

Insurance Group #: ______________________________

Insured Person's Birth date: ______________________________

Insured Person's Employer: ______________________________

Name of Insurance Co.:______________________________

Name of Insured Person:______________________________

Secondary Insurance ID#: ______________________________

Insured's SSN: ________-_______-___________

Relationship to Insured: Self/Spouse/Parent/Guardian/Other

Insurance Group #: ______________________________

Insured Person's Birth date: ______________________________

Insured Person's Employer: ______________________________

Print Name: ______________________________ Date: ____________________

Name of minor (if applicable): ______________________________

Signature: ______________________________

AUTHORIZATION TO RELEASE INFORMATION

I authorize: North Wind Behavioral Health
Clinician: ____________________
1867 Airport Way, Suite 215, Fairbanks, AK 99701-4062
Phone Number: (907) 456-1434 Fax Number: (907) 456-1481

To (release to) / (receive from) / (both): **PLEASE CIRCLE ONE**

Name: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip: ____________________

Phone Number: ____________________ Fax Number: ____________________

Please place your initials on the line(s) that describe the types of information you desire released.

_____ No Limitation
_____ Treatment Summary
_____ Assessment Report

_____ Psychological Testing Information
_____ Medical History, Physical Exam
_____ Diagnosis, Services Provided, Dated

_____ Other specific limitations and/or dates: ____________________

____

This information will be used for my evaluation, treatment, follow-up care, and/or to determine benefits payable and claim insurance for treatment services.

I understand that authorizing the disclosure of the above information is voluntary and I need not sign this form to ensure treatment. I hereby release both the above parties from any liability that may result from furnishing the information released. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that; in any event, this consent shall expire 90 days after completion of services provided by the North Wind Behavioral Health.

I understand that once the above information is disclosed, it may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws or regulations. It is understood that the policy of the North Wind Behavioral Health is to release only that information about a client or a former client which, in the judgment of the Clinician, is considered essential to the purposes for which authorization is requested.

Date: __________ Client Name: ____________________ DOB: __________
(PRINTED)

Witness: ____________________ Client Signature: ____________________

Parent/Legal Guardian: ____________________

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA — PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY — SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED — Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY — STATE

8. RESERVED FOR NUCC USE

CITY — STATE

ZIP CODE — TELEPHONE (Include Area Code) ( )

ZIP CODE — TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY — SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO — PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED — DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY — QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE — 17a. — 17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO — $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) — ICD Ind.

A. B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE — ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED — DATE

32. SERVICE FACILITY LOCATION INFORMATION — a. b.

33. BILLING PROVIDER INFO & PH # ( ) — a. b.

Informed Consent for Counseling and our Fee Policy Agreement

Welcome

The North Wind Behavioral Health welcomes you as a potential client. We believe it is important for you to be informed about the nature of counseling, psychotherapy, and medical management, the policies and procedures governing the help you will receive here, the fees charged for our services, and your rights as a client. After you have read this statement we ask that you sign the Acknowledgement form, signifying your general consent to therapy.

Therapy Process

Therapy begins with an *intake process* designed to evaluate your needs and difficulties and to help you and the therapist make a decision about engaging in therapy. This may take one interview or a series of interviews. If becoming a client here does not seem feasible, we can provide you with a suitable referral. The therapy process itself may take many forms, depending on the issues that need to be addressed and how far you wish to go in dealing with them. Treatment is guided by a treatment plan that you and your therapist both agree to pursue. North Wind Behavioral Health's methods of treatment are based on standard psychological models which are enhanced by the counselor's theological/spiritual perspective. These methods may be combined with the client's value and belief systems, including the client's religious perspective, if any. Treatment alternatives are available and you have the right to inquire about the duration of therapy and seek additional opinions concerning treatment.

Therapy Policies and Procedures

Confidentiality

What you tell your therapist will be kept strictly confidential and will not be revealed to other persons or agencies without your written permission, except when mandated by state and federal statues. By law, there are circumstances when the therapist must report information to the appropriate persons or agencies. These are listed in the Notice of Privacy Practices.

We make a practice of notifying the professional person or organization that referred you to the North Wind Behavioral Health after you have come in for an initial interview. If you do not want the Clinic to contact the person or organization please mark No on the Acknowledgement Form.

Please be aware that your case records may be viewed by North Wind Behavioral Health staff, consultants, and accreditation reviewers for purposes of diagnosis, treatment and quality control. In all other instances, your written permission is required before your therapist or the Clinic can reveal information about your treatment.

Emergencies

Our Clinic is not an emergent care facility, nor do we provide after hours emergency care. If you have an urgent concern, your counselor will try to schedule an appointment with you as soon as possible. Should you need emergency services, you should call 9-1-1 or go to the nearest emergency room. You may also call the Crisis Line at 452-HELP or 453-4357.

Fees and payments

FEES: Masters level counseling fee is $266 per hour ($285 for initial session per hour).
Psychiatric Service fees vary based upon level of service. i.e. Counseling $315 an hour + with Meds = $330 an hour
Initial Psychiatric Evaluation for Advanced Nurse Practitioners is $399 (1.5 hour), Medication ½ hour=$219.

Fees for counseling are based on the standard therapeutic hour, which is a 45 to 50 minute session. Appointments with our Psychiatric Nurse Practitioner are based on a one and 1/2 hour initial psychiatric evaluation and follow-up appointments which are 20 to 30 minutes sessions for medication management and 45-50 minutes for therapy sessions.

I understand that in the event this account is more than 60 days overdue, a collection agency may be used to collect those fees. If this occurs, I understand that I waive the right to confidentiality regarding financial information given by the North Wind Behavioral Health to a collection agency.

Appointments and Cancellations

All appointments are made directly with your counselor or front office staff. If you are unable to keep a scheduled appointment, please notify your counselor, or front office. You may also leave a message on the North Wind Behavioral Health's telephone answering machine at least 24 hours in advance.

All clients will be charged the therapist's standard fee for cancellations made with less than 24 hours notice or for failure to show for an appointment. Note: This charge is not covered by insurance. Unforeseen emergency situations will be taken into account.

Weather Cancellations

When Fairbanks North Star Borough closes school due to inclement weather, or when temperatures at the Fairbanks International Airport reach -50 or colder, the Clinic will close.

Insurance and Other Third-Party Payments ********* Please Read This Section **************

You are responsible for determining if your health insurance covers psychotherapy. If your mental health benefit is accessed through a Managed Care Agency, North Wind Behavioral Health will file your claims. If you have regular indemnity insurance, you can file the claim or North Wind Behavioral Health can file the claim for you. North Wind Behavioral Health does not guarantee that your insurance company will pay your claim. You are responsible for your account balance. You need to give the Clinic your correct and complete insurance information. If you are covered by more than one policy we need that information. If given incomplete or incorrect information and the insurance company does not pay or asks for a refund, you will be responsible to pay for those services. The HCFA form completed at the first session will provide the Clinic with all the information needed to produce a claim each month. The HCFA also has a release that allows the Clinic to provide necessary information to the insurance company.

Ending Therapy

Therapy ends when the work is done, or at the point you decide to end it. We request that you have at least one face-to-face termination session with your counselor to discuss reasons for termination rather than you terminating by phone or mail. This final session allows time to finish the therapeutic process or provide you with a suitable referral if the connection between you and the therapist is unsatisfactory.

Medication Management

Medications prescribed by our clinician will generally be renewed, as clinically appropriate, during your appointment. If you miss an appointment and/or call the Clinic for a medication renewal that is needed within 5 days or less of your call, you will be charged $35. This charge is not covered by insurance. Please make every effort to call at least a week in advance of needing a medication renewed in order to avoid this charge.