Family Behavioral Health Associates, LLC

Patient Registration Form

Today's Date: _____ Patient Name: _____

Nickname: _____ Date of Birth: _____ Age: _____ SSN: _____

Gender (circle one): M or F Marital Status (circle one): Single Married Separated Divorced Widowed

Address: _____
**Street address is required. If you have a P.O. Box, we will use it for correspondence

Home Phone #: _____ Work #: _____ Cell #: _____
Is it ok to leave medical or confidential information in a VOICEMAIL at the above #'s? Y or N (circle one)

Email Address: _____ Employer or School: _____

May we contact you at work? Y or N (circle one)
**Emergency Contact (name/ phone/ relationship) _____

Responsible Party, if patient is a minor (under 18 years of age)
*** The information below must be the parent/ guardian who is present at the appointment*

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security Number: _____ Relationship to Patient: _____

Email: _____ Employer: _____

Address (if different): _____

Home Phone #: _____ Work #: _____ Cell #: _____
***** May we contact you at work? Y or N (circle one)***

Other Parent/ Guardian Name: _____ Primary Phone #: _____

Insurance Information ***Please complete even though we have a copy of the card*

Insurance Company: _____ Phone #: _____ Member ID: _____

Group #: _____ Policyholder Name: _____ DOB: _____

Policyholder SSN: _____ Relationship to Patient*: Self/ Spouse/ Child/ other* (circle one) _____

Policyholder address: _____

Policyholder Phone #: _____ Policyholder Employer: _____
Are these visits covered by an Employee Assistance Program? Y or N (circle one)
If YES, name of program and phone: _____
Authorization #: _____ # of Visits: _____

X _____ _____ _____
(Signature of Responsible Party) (Print Name) (Date)

Patient Primary Care Physician (PCP): _____ Phone #: _____

Date of last visit and purpose: _____

Current Medications:	**Doctor Prescribing**:	**Dose**:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who/ How were you referred to our practice? _____

Have you received counseling, psychological, or psychiatric services in the past? Y or N

If yes, Professional's Name: _____ Date Began: _____ Date Ended: _____

Please check any of these, which have been a problem in the last six months:

Anxiety	_____	Concentration Problems	_____
Excessive Worrying	_____	Memory Problems	_____
Panic Attacks	_____	Educational Problems	_____
Extreme Fears	_____	Work/ Career Problems	_____
Shyness	_____	Legal Problems	_____
Loneliness	_____	Financial Problems	_____
Unhappiness	_____	Alcohol Use	_____
Depression	_____	Substance Abuse	_____
Suicidal Thoughts	_____	Sexual Problems	_____
Inferiority Feelings	_____	Marital Problems	_____
Lack of Energy	_____	Separation/ Divorce	_____
Indecisiveness	_____	Loss of Family Member	_____
Lack of Motivation	_____	Problems with Children	_____
Overtiredness	_____	Gay/ Lesbian Issues	_____
Excessive Energy	_____	Problems with Friends	_____
Anger Problems	_____	Headaches	_____
Lack of Self Control	_____	Major Illness	_____
Nightmares	_____	Eating Problems	_____
Sleep Problems	_____	Health Problems	_____
Undue Stress	_____	Other	_____

Reason for seeking help at this time:

_____
_____
_____
_____

Please add any other information that you believe may be helpful:

_____
_____
_____
_____

Consent for Treatment

(*Please complete section A or B and sign below as indicated)*

A. ☐ I, the undersigned, do voluntarily consent to psychiatric/ behavioral health assessment and/ or treatment for myself by_____.

B. ☐ I, the undersigned, am the legal guardian of _____ (child's name) Date of Birth _____, a minor child. I do voluntarily consent to his/ her psychiatric/ behavioral health assessment and/ or treatment by: _____.

Consent for Treatment

- I understand that like the other healing arts, psychiatry and behavioral health are not exact sciences and no guarantees are being made as to the results of assessment and/ or treatment.
- I am aware that I am an active participant in this endeavor and that I share the responsibility for the treatment process.
- I understand that assessment and/ or treatment will be kept confidential with the exception of legal limitations of confidentiality. In addition, I am aware that, although the above-named practitioner is clinically independent, consultations with other practitioners are sometimes advisable, and my signature below gives the above-named practitioner permission to do that.
- I understand that when the above named practitioner is unavailable, another physician or behavioral health provider may be providing emergency coverage. I understand the practitioner providing the coverage may be given access to relevant information in order to provide the best interim care possible.
- I authorize release of any information necessary to process any insurance claims. This would include an ongoing release of information to meet managed care review requirements.
- If you are a member of a Managed Care Organization a "Members Rights and Responsibilities" document may be available to you.
- FBH has provided me with the opportunity to read the Notice of Privacy and all of my questions have been answered.
- You have the right to revoke this consent in writing and terminate services with the above named therapist at any time. In that event, your practitioner or FBH staff is willing to help you locate alternative resources in the community.

I have read and understand the information on this sheet. My signature indicates my *informed consent* with the above-named practitioner. ***If you have any questions about this form, please discuss them with your practitioner.***

X _____ _____ _____

(Signature) **(Relationship to Patient)** **(Date)**

**** In order to provide the best care possible, your physician/ behavioral health care provider would like to be able to communicate with your Primary Care Physician (PCP.)**

Please check one of the following: ☐ I DO or

☐ I DO NOT give FBH permission to exchange my protected health information or my child's protected health information with our PCP.

_____ _____

(Signature of patient or parent/ legal guardian) (Date)

Financial Agreement

**Please read this carefully and keep attached patient copy for your records.

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BILLING: Our clinicians participate with many insurance companies and in most cases we will bill your insurance company for you. *However*, you are ultimately responsible for your bill. If you have not already done so, contact your insurance company to find out what your mental health benefits are, including deductibles, copayments, requirements for preauthorization, and any limitations to your coverage.

IT IS YOUR RESPONSIBILITY TO OBTAIN ANY INITIAL PREAUTHORIZATION REQURED BY YOUR INSURANCE COMPANY. FAILURE TO DO SO BY THE END OF THE BUSINESS DAY ON THE DAY OF YOUR INITIAL APPOINTMENT MAY RESULT IN DENIAL OF COVERAGE AND LEAVE YOU RESPONSIBLE FOR PAYMENT OF THE FULL FEE.

Fees not covered by your insurance company are due at the time of service. These fees include, but are not limited to, copayments or co-insurance, deductibles, charge for telephone consultation, school meetings, educational testing and services, most court-ordered services, letter and report writing, prescription refills in between appointments, and depositions/ court appearances.

COLLECTION PROCEDURES: Unless arrangements have been made, bills that are more than 90days delinquent will be turned over to a collections agency. In that event, you will be liable for an additional collection cost of 33% current balance. You will also be responsible for an interest rate of 1.5% per month on the unpaid balance. If you are unable to afford the cost of treatment, your clinician will assist you with a referral to your community mental health center.

CHANGE IN INSURANCE: It is your responsibility to notify both your clinician and the billing office of any changes to your insurance coverage and to provide us with any new insurance cards. It is also your responsibility to contact your new insurance company to obtain any preauthorization that may be required. Failure to do so may result in denial of coverage and may leave you responsible for payment for the full charges.

YOU ARE REQURED TO GIVE AT LEAST 24-HOUR NOTICE WHEN YOU NEED TO CANCEL AN APPOINTMENT. MONDAY APPOINTMENTS MUST BE CANCELLED BY THE APPOINTMENT TIME ON THE PRECEEDING FRIDAY. IF YOU CANCEL AN APPOINTMENT WITH LESS THAN 24-HOUR NOTICE OR IF YOU FAIL TO SHOW UP FOR YOUR APPOINTMENT, YOU WILL BE CHARGED A FEE WHICH IS NOT COVERED BY INSURANCE.

If you arrive late for your appointment, your clinician may see you for only the remainder of your scheduled appointment time or may request that you reschedule if insufficient time remains. While we make every effort to begin appointments on time, other patient needs do sometimes result in your therapist running behind schedule. When this happens, you will generally be offered the option to run late and still be seen for a full appointment or reschedule.

TELEPHONE CALLS: Please try to keep telephone calls brief. Try to save any questions that you have for your clinician and ask them during your scheduled appointment times. Except for emergencies, your clinician will charge the hourly rate for telephone calls that are longer than 5 minutes and for frequent phone calls.

CLOSED CASES: Accounts will be considered closed if the last visit was more than 12 months ago.

OTHER RESPONSIBLE PARTIES: To avoid confusion, the person consenting to treatment will be responsible for all fees not covered by insurance. If another party is legally responsible for medical bills not covered by insurance (for example, in case of divorced parents, your child's other parent) we will provide you with whatever documentation you need in order to get reimbursed by that person. We will not bill that party directly however.

_____ _____

(Patient Name – please print) (Responsible Party Name – please print)

_____ _____

(Signature of Responsible Party) (Date)

Written Acknowledgement Form

Our *Notice of Privacy Practices* provides you with information about how we may use and disclose Personal Healthcare Information about you. As provided in our Notice (see attached copies), the terms of our notice may change. If we change our notice, you may obtain a revised copy.

I, _____ (Please print patient name) have received a copy of FBH Notice of Privacy Practices.

I understand that I may ask questions of my clinician, if I do not understand any information contained in the Notice of Privacy Practices.

X _____ X _____
(Patient Signature) (Date)

X _____ X _____
(Parent or Guardian Signature if under 18) (Date)

FEE SCHEDULE
***Unless noted otherwise, fees for services are as follows:*

Self Pay Rates (IF NOT COVERED BY INSURANCE):

	William Burke, Ph.D.	**Laurie Burke, PMHNP/ CNS-BC**
• Initial Evaluation Appointment	$200	$250
• Ongoing Follow Up: (depending on duration of visit)	$100 - $200	$100-$160 (Med Check Only) $75 - $125 (Therapy Add On)

FEES NOT COVERED BY INSURANCE:

• Deposition/ Court Appearances (includes travel time)	$250/ hour
• Letter of Physician Statement	$70
• Telephone Calls (more than 5 minutes and non emergency)	$100/ hour
• Completion of Health Disability Forms	$20-$50
• Copy of Medical Records Processing Fee (plus $.50 per page up to 50 pages and $.25 per page thereafter)	$10
• No Show or Late Cancellation Fees (Depending on scheduled appointment duration/ 30 or 60 minute)	$50-$75

X _____ (Initial Here)

FAMILY BEHAVIORAL HEALTH ASSOCIATES, LLC
Policy Regarding Health Insurance

Many insurance plans today require patient payments in the form of Deductibles, Copayments, and/ or Coinsurance. Your insurance plan is structured to pay toward outpatient services following your payment of Deductible and Copayment.

To help manage the various plans and maximize the accurate filing of your insurance claims, we have established the following policies:

DEDUCTIBLES AND COINSURANCE:

FBHA has developed a practice requirement that for all visits on policies where the deductible has not been met and we have not yet received an Explanation of Benefits from your insurance company, the patient will be required to make a payment of $75 at the time of each office visit. We will then file the claims directly to your insurance plan. Once we receive an EOB from your insurance plan that informs us of the UCR for your policy, adjustments (increase or decrease) in your discounted payment will be made if needed. Remember, the payment is the amount you pay at each visit toward your Deductible or Coinsurance.

COPAYMENTS:

FBHA has developed a practice requirement which matches the policy of your specific insurance plan. FBHA will accept the copayment in the amount reported by your insurance plan or published on your insurance card and verified. Payment of the specified copayment will be made upon each outpatient visit.

CREDIT CARDS:

For your convenience, FBHA will accept a valid credit or debit card to be placed on file for the periodic payment of Deductibles and Copayments.

X _____ I understand the policy and accept.
(Initial here)