



First and Last Name: _____ DOB: _____ Sex: ___M ___F

Preferred Name: _____ SSN: _____ Marital Status: ___Single ___Married ___Divorced ___Widowed

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

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____ Ext. _____

Email: _____ Appointment Reminder: Call Text Email

EMERGENCY CONTACT

Emergency Contact: _____ Phone: (_____) _____ Relationship: _____

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

I give MBHA permission to discuss the following with the individual above: (check all that apply)

- Appointments Billing Treatment/Medication

OFFICE POLICIES

Full payment for professional services is due at the time of services. If you are unable to pay your co-pay or deductible, you may be asked to reschedule your appointment. Any patient with a balance over 90 days must pay the balance in full before an appointment can be scheduled. Tardiness: Please call if you running late. Patients arriving more than 15 minutes late may be asked to reschedule. Cancellations: If you are unable to keep your appointment, please contact our office at least 24 business hours prior to the scheduled appointment time. Patients that do NOT contact the office within the 24 hour period to cancel their appointment will be charged a \$50 fee for the missed appointment. We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice. Medication Refills: most medications require a follow up appointment to be refilled. If you find that you are running low on a medication, please call our office and we will address the situation. Returned Checks: Will be processed with a service charge of \$40. Outstanding patient balances over 30 days will accrue a monthly 1.5% interest charge. Balances referred to collection services are subject to additional fees. Paperwork Charge: \$50 charge for paperwork, reports, etc. Requests exceeding (2) pages may incur additional fees. These paper work requests will take up to the allowed 10 business days from the date we receive written request. A charge of \$5.00 may be applied for medical records requested by the patient. Record requests can take up to 15 days after receiving a signed release of information. If records are requested to be sent through email, the release of information must state that specifically with the email address. Insurance/Referrals: As required by your insurance carrier, you are responsible for obtaining any necessary referral if your insurance policy mandates such paperwork. In the event that you are seen without the proper referral/authorization as required by your insurance, you will be responsible for payment of all fees/services rendered. Subpoena for Witness: If any of the providers are subpoenaed for court, the fee is \$250/hr. for a minimum of 4 hours. This fee includes preparation time, travel, waiting, testifying, etc. Additional fees may be assessed if travel out of the immediate area is required. Payment in full is required 7 business days in advance of the scheduled hearing. This fee continues to apply even if the provider does not testify. Additionally, fees will remain in effect in the event that court is canceled, continued, or rescheduled less than 3 business days prior to the court appearance for any reason. (e.g. weather, the judge cancelling the day, settlement of the case outside of court, etc.). By signing this, you are authorizing release of information, including financial information and confidential health information and medical records for services rendered regarding your condition, which may include records related to treatment for substance abuse to your insurance carrier(s), managed care plan or other party, past or present employer(s), authorized private review entities or entities acting on their behalf, authorized chart reviewers, the billing agents, collection agents, our attorneys or insurance companies, the Social Security Administration, the Health Care Financing Administration, the Peer Review Organization acting on behalf of the federal government, and/or any other federal or state agency for the purpose of satisfying billed charges and/or facilitating utilization review and/or otherwise complying obligations of state or federal law. In your capacity as a patient, legal representative or representative payee for the patient, you agree to pay all the charges for which you may be legally responsible including but not limited to health insurance deductibles, co-payments, and non-covered services. In the event your account must be placed with an attorney or collection agency to obtain payment, you agree to pay reasonable attorney's fees and other collection costs.

By signing below I certify that I have read and understand MBHA's office policies.

Patient/Guardian Signature: _____

Date: _____