Behavioral Health Associates

PATIENT INTAKE

Date _____

Last Name _____ First Name_____ Middle Initial _____

Gender M ___ F ___ Date of Birth _____ Marital Status _____

Address _____

City _____ State _____ Zip _____

Telephone(s)

Home _____ **Work** _____ **Cell** _____
Please include area codes ***needed for reminder***

Email Address _____
Needed for appointments reminder

Preferred method of appointment reminders: Cell___ (text and voicemail) Email____

Primary Language: English___ Spanish___

Emergency Contact Name _____

Emergency Contact Phone(s) _____Relationship_____

Referred by: PCP___ Psychiatrist___ Other ____

May we contact your referral source to verify that you made your appointment? Yes No

INSURANCE INFORMATION

(Please present Insurance Cards and Picture ID for copy)

Primary Insurance Name_____ Secondary Insurance Name _____

Primary Insurance ID# _____ Secondary Insurance ID#_____

Group Number _____ Group Number _____

Subscriber Name _____ Subscriber Name _____

DOB of Subscriber _____ DOB of Subscriber _____

Relationship to subscriber _____ Relationship to subscriber _____

Authorization Number _____ Exp Date _____
(Office use only)
Co-pay _____ Visits allowed _____

(Revised 08/21/2018)

PATIENT INTAKE (cont)

Have you received previous mental health services? Yes No

If yes, when and from who? _____

Please list all medications that you are currently taking _____

_____

_____

_____

Please list any chronic physical illnesses that affect mood _____

_____

_____

_____

Do you have any chronic pain issues? Yes No

If yes, please indicate location, intensity, duration, and how it is managed

_____

_____

Do you have problems with substance abuse now, or in the past? Yes No

If yes, please list substances, duration of use, and year of abstinence, if any

_____

_____

Please list any potential barriers to treatment _____

Do you have any Advanced Directive (Living Will)? Yes No

If you do not, would you like information on how to obtain an Advanced Directive? Yes No

History of self-injurious, self-mutilating, suicidal, or aggressive thoughts or behaviors

_____

_____

Please list the reason(s) you sought treatment and your expectations from treatment

_____

Behavioral Health Associates

AUTHORIZATION FOR TREATMENT

Behavioral Health Associates is a d.b.a. (doing business as) titled entity, made up of individual behavioral health providers. Each provider in this office is an independent practitioner, solely responsible for their own care provision, record keeping, and scheduling. The practitioners have agreed to share space, clerical support, and expenses, but remain separate entities in terms of business enterprise and service provision. As colleagues in an associated practice, we have agreed to share on-call services for emergencies, and have the ability to assist each other with scheduling and limited clerical and emergent service delivery, but each practitioner is responsible for their own patient base. If you should have any questions regarding this structure, please do not hesitate to discuss it with your provider.

Patient Notices:

1. There are several limitations to confidentiality of which you need to be aware.
    a. If you threaten to harm yourself or someone else, we must take steps to prevent that, which may include notifying law enforcement for assistance.
    b. Should it be found that unreported child abuse has, or is occurring, this must be reported to the proper authorities.
    c. Managed care may require a plan of treatment, request for confidentiality standards, and periodic treatment reports and responses.

2. There are many patients trying to secure services and we take our time seriously. For that reason, we have initiated the following policy;
    a. If you do not show for a scheduled appointment, or call within 24-hours to cancel, you may be charged a $60.00 fee that must be paid before your next appointment.
    b. If you fail to show for a scheduled appointment, and you have pre-booked consecutive appointments, we may cancel them.
    c. No shows can be grounds for immediate termination of services.

By my signature, I agree to engage in behavioral health services with my assigned provider, and authorize my practitioner to apply for benefits on my behalf for covered services. I request that payment from my insurance carrier be made directly to my practitioner. I authorize the release of any information necessary to process the claim. Further, I understand that I am responsible for payment of any deductibles, co-payments, or non-benefit exclusions; regardless of insurance claims. I also acknowledge that I understand the content of this authorization.

_____ _____

Patient/Legal Representative Signature Date

Behavioral Health Associates

PRIVACY STATEMENT

PRIVACY PRACTICES: This notice describes how medical information about you may be disclosed and how to get access to information.

Treatment is the provision, coordination, or management of healthcare and related services by one or more healthcare providers. This includes the coordination or management of healthcare by a provider with a third party, consultation between healthcare providers relating to a patient, or referral of a patient for healthcare from one provider to another.

Example: A copy of your record is released to your psychiatrist with your consent in order to better coordinate care.

Payment is the activity undertaken to obtain reimbursement for healthcare provided to you. This includes determination of eligibility, adjudication of claim, risk management, billing, claims management, collections, obtaining payment, data processing, justification of charges, utilization review, appropriateness of care, and disclosure to consumer reporting agencies relating to collection of reimbursement.

Example: Supporting documentation from your medical chart to justify claim to your insurance carrier.

Healthcare Operations means performing activities related to covered functions including quality assessment, competence review, medical review, legal services, auditing functions, and fraud/abuse detection and compliance programs.

Example: A consultant may review a medical record for appropriate documentation.

You have the right to restrict disclosures to individuals who may be involved in your care, receive confidential communications, inspect and copy protected health information about you, request amendment to your medical record, and request an accounting of disclosure.

Emergency Call: Patient requiring assistance in an emergency may have their calls returned by an associate on-call at that particular time. All emergencies will be attended to by a qualified, Florida licensed mental health practitioner.

Provider/Patient Communication: Provider and patient have the right to contact each other using information stated on the intake form. This communication is via phone calls, mailing, texts, and/or emails. This includes permission to receive reminders through our EHR program, Practice Fusion.

For further information, you may contact our Compliance Officer.

_____ _____

Patient/Legal Representative Signature Date