**PATIENT INFORMATION:**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Gender:**  **Male \_\_\_\_\_ Female \_\_\_\_\_ Marital Status: Single** \_\_\_\_\_ **Married** \_\_\_\_\_ **Widowed** \_\_\_\_\_

**Employer** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Student/School:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip:** \_\_\_\_\_\_\_\_\_\_\_\_

**Physical Location:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Zip:**\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phones: Home #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

May we leave a message (if voice mail available) on the phone #’s listed above? **NO** \_\_\_\_\_  **YES** \_\_\_\_\_

**DO NOT** leave message on: \_\_\_\_\_ **Home** \_\_\_\_\_ **Cell** \_\_\_\_\_ **Work**

PERSON FILLING OUT FORM (**AS YOU ARE RESPONSIBLE FOR THE BILL**): ***Same info as above Yes\_\_\_ No \_\_\_\_\_***

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SS#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phones:** **Home #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Cell #**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work #** \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **City:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Zip**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on the phone #’s listed above? **NO** \_\_\_\_\_ **YES** \_\_\_\_\_ **Except for:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT (if we are unable to contact you, who should we call)**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Phones:** **Home #:** \_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_ **Cell #:** \_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on the phone #’s listed above? **Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **Except for:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY INSURANCE INFORMATION:**

**Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SECONDARY INSURANCE INFORMATION:**

**Name of Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grp#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_ Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I consent to be treated and/or to have my child treated by Borealis Behavioral Health, LLC. I authorize the RELEASE of all medical information to process my insurance claim. I authorize my insurance benefits to be paid directly to Borealis Behavioral Health, LLC. I also acknowledge responsibility for payment of my account regardless of my insurance coverage. I agree to pay any collection costs and/or attorney fees incurred in attempting to collect any delinquent balances.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 03/28/2023

**BOREALIS BEHAVIORAL HEALTH, LLC**

**OFFICE POLICIES**

Your decision to come to us for your mental health needs is an important one and one that we take seriously. This can be a vulnerable process in which trust is an essential element. It is our desire that your work here will prove beneficial to you. ***Please read and initial each section of this form and sign at the bottom indicating that you understand and agree to these policies***.

**HOURS:** Monday from 9:00am to 1:00pm and Tuesday through Thursday 8:00 am to 6:00 pm, closed for lunch 12:00 to 1:00p.m. If we don’t answer during business office hours, it could mean that office staff is helping another patient or on another phone call, please try calling back. If our hours change, during holidays or special events, we will post them outside our office as well as put them on the answering machine. **\_\_\_\_\_\_ (initials)** **REFILL REQUESTS**: Monitor your medication supply so that you do not run out between appointments. ***Refills outside of your appointment may be billed to you at the rate of $25.*** This will be billed to you and not insurance. If you need a refill on a medication that you have previously received from our office, call your pharmacy. They will fax us your request. If you need a new prescription, call our office. **We do require 3 business days on all medication requests**. **Please take 3-day weekends and holidays into consideration when calling in for refills**. If you have not been seen in some time, we may be unable to refill your medication until you have been seen**.** If refills are more urgently needed, you may wish to see your primary care physician or an urgent care clinic that allows “walk-in” patients.  **For your safety, please inform us of any newly prescribed medicines from other prescribers and of any medication allergies.** Most medications for ADHD or a controlled substance require a written prescription that will need to be picked up. \_\_\_\_\_ **(initials)**

**TREATMENT**: We will make every attempt to schedule your initial visit with a clinician that best meets your needs. However, please be aware that the initial visit is an evaluation. The decision to begin treatment or make other arrangements is not made until after the evaluation is completed. During the evaluation, your needs, expectations, and our recommendations will be discussed. A treatment relationship does not exist until you and the clinician you are seeing both agree to one. \_\_\_\_\_ **(initials)**

**TELEMEDICINE:** This office does utilize the option for telemedicine. This is a two-way audio and video option that can be used for all appointments other than the evaluation. To use telemedicine, you need to have access to a computer or phone that has video and audio capabilities. You will need to provide a working email address to receive the link for doxy.me. We suggest that you save that link for any future appointments***. If you utilize your option for telemedicine and you take a controlled substance you will need to be seen in the office a minimum of 4 times a year required by the DEA***

*.* \_\_\_\_\_ **(initials)**

**ATTENDANCE/CANCELLATIONS/NO SHOW AGREEMENT** Missed appointments are not beneficial to patients or our practice. When a patient misses an appointment, s/he goes without an important service, and prevents us from scheduling with another patient. Therefore, a “***NO SHOW” fee of $50 will be charged if an appointment is not canceled at least one full workday in advance. The $50 fee will need to be paid at or prior to the next appointment***. This will be billed to you, not to your insurance.  **I understand that confirmation calls are a courtesy and that I am ultimately responsible for remembering my appointment.** I understand that I can leave a message on the answering machine if no one is available to take a cancellation call. I understand that three “no shows” may lead to discharge from the clinic or a full fee charge for the cost of the third and following appointments**.** If you are ill on the day of your appointment and you

# call to cancel in the morning, your clinician may excuse the “no show” fee. \_\_\_\_\_ (initials)

**NO ON-CALL OR EMERGENCY AVAILABILITY**: Our Office is small and does not offer after hours on-call services. If you anticipate that you may need emergency services outside of regular business hours, you might want to consider a larger office. The Emergency Room at all hospitals are always available should a crisis occur after hours. We may be able to provide you with referral options if you find this unacceptable for your needs **\_\_\_\_\_ (initials)**

**CHILDREN**: Children under the age of 18 must have a treatment consent form signed by a parent or guardian to be seen for the initial appointment. Young children should not be left unattended in the clinic. We will not be responsible for children that leave the premises or that are injured due to being left unattended. ***It will be understood that separated or***

***divorced parents with shared legal custody of their children will be responsible for communicating together regarding***

***their children’s appointments and treatment.* \_\_\_\_\_ (initials)**

Please sign below to indicate that you have read, understand, and agree to the information on this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Date Name of Patient

Revised 03/28/2023

**BOREALIS BEHAVIORAL HEALTH, LLC**

**FINANCIAL POLICY**

Thank you for choosing Borealis Behavioral Health, LLC, as your health care provider. We are committed in making your treatment be successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to service. Please let us know if you have any questions.

***ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECKS, OR***

***VISA/MASTERCARD***

**REGARDING INSURANCE PLANS IN GENERAL**: ***As a courtesy***, we will file your insurance for you. To provide this service, we will need your correct insurance information and signed authorization. Services not covered by your plan are your financial responsibility. You should call your insurance carrier and determine what services are covered, any pre-certification requirements and the amount of coverage you have. Please be aware any ***unpaid balance* by your insurance, *after 2 months from the date of service, will be your responsibility regardless of insurance benefits****.* Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

**USUAL AND CUSTOMARY RATES**: Our practice is committed to providing the best treatment for our patients and we charge what is considered usual and customary for our profession in our area. You are responsible for this amount regardless of any insurance company’s arbitrary determination of usual and customary rates (unless we have specific agreement with your insurance plan as a preferred provider).

**COURT APPEARANCES**: If a court appearance or report preparation is requested or required, the standard hourly rate will be billed. Please ask us regarding these rates, as they will vary by providers.

**OTHER CHARGES:** Time spent working on your behalf outside of an appointment may be ***billed to you at the rate of $25 per occurrence. These charges are not reimbursed by insurance***. This may include (1) medication refills, (2) telephone contact, (3) requests for special letters, (4) requests for the completion of various forms, (5) requested or medically necessary care coordination with providers outside our office, and/or (6) after hour contact.

**MINOR PATIENTS**: An adult (foster parent, aunt, uncle, etc.) accompanying a minor and/or the parents (or legal guardians) are responsible for payment. ***Foster parents and support agencies providing transportation need to be aware that they will be responsible for “missed appointments” when appointments are not kept***.

**OVERDUE ACCOUNTS & INSUFFICIENT CHECKS**: We do not depend on outside collection services unless accounts become unreasonably delinquent. We would much rather communicate with you to find some solution to overdue accounts. However, when there is no communication, your account will be turned over to our Collection Agency. Additional charges may be added to your balance such as administrative fees and/or interest charges **prior** to being turned over. In addition, the Collection Agency may be adding additional interest charges/fees.

***Personal checks returned to us for lack of sufficient funds will be subject to a $30 fee by us***. Additional fees by a Collection Agency will be added.

\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns. Please sign below to indicate that you have read, understand, and agree to the information on this form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Legal Guardian Date Name of Patient

Revised 03/28/2023

**BOREALIS BEHAVIORAL HEALTH, LLC**

**NOTICE OF USE OF PRIVATE HEALTH INFORMATION**

***FOR YOUR PROTECTION***: This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

***YOUR HEALTH INFORMATION IS PRIVATE***: We understand that information we collect about you & your health is personal. Keeping your health care information private is one of our most important responsibilities. We are committed to protecting your health care information and follow all laws regarding the use of your health care information. The law says:

1. We must keep your health care information from others who do not need to know it.
2. You may ask us not to share certain health care information. In some instances, we may not be able to accommodate your request.

***HOW IS PAYMENT MADE?*** We may exchange information about you with your health plan, your insurance company, or government programs to obtain payment for our services and to help you maximize your benefits.

***MAY I SEE MY HEALTH INFORMATION?*** Under most circumstances, you may see your health care information. There may be limitations on this right for legal reason, or if your safety is at risk. If you think some of the information is wrong, you may ask in writing that correct or new information be added. You may ask that the corrected or new information be sent to others who have received your health care information from us. You may ask where we sent your health care information and we will provide you a list, excluding information sent for treatment, payment, and health care operation.

***WHAT IF MY HEALTH INFORMATION NEEDS TO GO SOMEWHERE ELSE?*** You will be asked to sign a

separate form, called a Release of Information form, permitting your health care information to go somewhere else. The authorization form tells us what, where and to whom the information must be sent. You can cancel or limit the amount of information sent at any time by letting us know in writing. You may be charged a small amount for copying costs. *NOTE: If you are younger than 18 years old and, by law, you can consent for your own health care, then your health care information is kept private unless you sign an authorization form. There are special rules governing chemical dependency releases, all patients no matter the age must sign*.

***COULD MY HEALTH INFORMATION BE RELEASED WITHOUT MY AUTHORIZATION?*** We follow laws that tell us when we must share health care information, even if you do not sign an authorization form. We always report:

1. To the police when required by law.
2. When the court orders us to.
3. To the government to review how our programs are working.
4. To a provider or other insurance company who needs to know if you are enrolled in one of our programs.
5. To Workers Compensation for work related injuries.
6. To the Federal Government when they are investigating something important to protect our country, the President and other government workers.
7. Abuse, neglect, and domestic violence.

We may also report serious threats to public health or safety.

***QUESTIONS OR COMPLAINTS?*** If you have questions or feel your privacy rights have been violated you can contact us by calling (907) 745-7080, or by writing to Borealis Behavioral Health, LLC, 634 S. Bailey St., Suite 207 Palmer, AK 99645. You can also complain to the federal government Secretary of Health and Human Services or to the HHS Office of Civil Rights. Your health care services will not be affected by any complaint made to the Privacy Officer, Secretary of Health & Human Services or Office of Civil Rights.

***ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE***: I have reviewed and understand this consent form:

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Revised 03/28/2023