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: _____

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**.**

. _____ **(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: _____ Date: _____

BOREALIS BEHAVIORAL HEALTH, LLC
FINANCIAL POLICY

Thank you for choosing Borealis Behavioral Health, LLC, as your health care provider. We are committed to making your treatment successful. Please understand that payment of your bill is considered as part of your treatment. The following is a statement from 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 120 days 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 provider.

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.

****

Signature: _____ Date: _____

Revised 10/01/2025.

BOREALIS BEHAVIORAL HEALTH, LLC
FINANCIAL POLICY AND AGREEMENT

If you have any questions or need clarification, please do not hesitate to ask the front desk any questions you may have. ***Please read and initial each section of this form and sign at the bottom indicating that you understand and agree to these policies***.

(initials) _____ I consent to treatment by the providers of Borealis Behavioral Health, LLC.

(initials) _____I understand that I am responsible for knowing my insurance company's benefits and limitations and that I will be responsible for any cost not covered by my insurance.

(initials) _____I authorize the release of pertinent medical information to insurance carriers.

(initials) _____I understand that I am responsible for informing Borealis Behavioral Health of any changes to my insurance within a timely manner and will be financially responsible for any charges accrued if the information is not submitted.

(initials) _____I understand that I am responsible for paying any co-payments, co-insurance and deductibles required by my insurance to Borealis Behavioral Health on the date of service.

(initials) _____I authorize Borealis Behavioral Health to charge my card on file for all co-pay's, co-insurance, missed appointment fees and balance over 120 days on the day the service was rendered.

I accept responsibility for the payment of all non-covered services to include:

(initials) _____Less that 24-hour notice for cancellation or No Call No Show fees ($50)

(initials) _____Non-sufficient funds fee for returned checks ($30)

(initials) _____Other charges accrued outside of an appointment ($25)

(initials) _____I understand that any outstanding balance may be turned over to a collections agency if the account becomes delinquent. (no payments over 120 days)

(initials) _____I understand that if my bill exceeds an amount of $350 and I do not have a payment plan in place any follow-up appointments are subject to cancellation until my balance is caught up.

My signature below indicates that I have carefully read the Financial Policy and Agreement, understood and accepted the terms of this agreement, and agree to my financial responsibility set forth in the agreement.

Signature: _____ Date: _____

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 the 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 reasons, 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 with 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 their 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) 917-4151, 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: _____

SOCIAL MEDIA POLICY

Borealis Behavioral Health LLC has social media accounts (Facebook and Google+), allowing us to share practice information, news and updates with other social media users. This document outlines our practice's policy related to use of Social Media. Please read it to understand how we conduct ourselves on social media sites as mental health professionals and how you can expect us to respond to various interactions that may occur between clients and clinicians on the Internet.

This policy is not meant to keep you from sharing that you are in therapy at Borealis Behavioral Health or with a particular therapist/ANP wherever and with whomever you like. Confidentiality means that we cannot tell people that you are a client. You are encouraged to take your own privacy as seriously as we take our commitment of confidentiality to you.

Friending/Liking/Following

Therapists/ANP'S do not accept "friend" requests from clients on their personal social networking sites (Facebook, Twitter, LinkedIn, etc.). Adding clients as "friends" on these sites can compromise your confidentiality and our respective privacy. It may also blur the boundaries of our therapeutic relationship. You are welcome to "like" or "follow" our social media feeds and read or share; however, because social media sites are public spaces, anyone who can see our social media pages can see your post or comment. In addition, when you post, comment, or "like" a page, it will be published on your page as well. Our primary concern is your privacy. You are welcome to use your own discretion in choosing whether to follow our practice. In order to maintain ethical boundaries, therapists/ANP'S are not permitted to follow you back. We believe casual viewing of clients' online content outside of the therapy time can create confusion in regard to whether it's being done as a part of your treatment or to satisfy curiosity. In addition, viewing your online activities without your consent and without our explicit arrangement towards a specific purpose could potentially have a negative influence on the therapeutic relationship. If there are things from your online life that you wish to share with your therapist/ANP, please bring them into the sessions where those things can be viewed and explored with your counselor/ANP during the therapy session.

Texting/ Messaging

Please do not use SMS (mobile phone text messaging), wall posting, @ replies, messaging on Social Networking sites in order to contact your therapist. Engaging with your therapist/ANP in this way could compromise your confidentiality and the therapist/ANP may not even receive your message. It may also create the possibility that these exchanges become a part of your legal medical record and will need to be documented and archived in your chart.

Use of Search Engines

It is NOT a regular part of our practice to search for clients on Google or Facebook or other search engines. Due to the fact that therapists/ANP'S are mandated reporters, extremely rare exceptions may be made during times of crisis. If a therapist/ANP has reason to suspect you are in danger and you have not been in touch with your therapist/ANP via usual means (coming to appointments, phone, or email) there might be an instance in which using a search engine (to find you, find someone close to you, or to check on your recent status updates) becomes necessary as part of ensuring your welfare.

Initials_____

BOREALIS BEHAVIORAL HEALTH, LLC

Electronic Correspondence

We have upgraded our means of communication for appointment reminders. We use Medisoft for all billing and scheduling means, this system contains sensitive information protected by HIPPA. We upgraded that system to include Auto Remind. Listed below is a description of the 3 methods of communication, please review each of these forms of communication and select which one you would prefer to receive appointment reminders.

☐ **Email**
Our email server is not secure, if you wish to receive communication via email it may contain protected health information (PHI). Please initial if you understand that this is form of communication will not be secure but still wish to receive emailed correspondence. Reminder will go out 1 day before your appointment at 10am.

____ Initial here if you would understand the above information and still wish to receive correspondence via email.

_____ Please list the email you would like to receive reminders.

☐ **Texting**
You may also opt to have your appointment reminders come via text. The text will come directly from Medisoft, our practice management system. Reminder will go out 1 day before your appointment at 10am.

_____ Please list the number you would like to receive reminders.

☐ **Phone**
Our main number is 907-917-4151. Our receptionist or office manager will answer it personally during regular business hours. If you leave a message, expect it to be returned within 24-48 hours. Phone conversation content, at the discretion of your clinician, will also be part of your clinical records. Reminder will go out 1 day before your appointment at 1pm.

_____ Please list the number you would like to receive reminders.

I agree to have Borealis Behavioral Health, LLC correspond with me according to the box(es) checked above.

_____ _____
Signature Date

BOREALIS BEHAVIORAL HEALTH, LLC
CREDIT CARD FORM

Patient's Name: _____

Type of Payment: ☐ Cash ☐ Check ☐ Credit Card

Type of Card: ☐ Visa ☐ Mastercard ☐ Amex

Name on Card: _____

Billing Zip Code: _____

Credit Card #: _____

Expiration Date: _____

Last 3/4 digits on back of card: _____

Payment Amount: _____

When to run card: _____

Signature: _____ Date:_____