Alabama Psychiatry

NEW PATIENT/CLIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Age: _____

Social Security #: _____ Marital Status: _____ Gender: _____

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

Primary Phone #: _____ (cell / home / work) Secondary #: _____ (cell / home / work)

Email Address: _____ Preferred Method of Contact: _____

Can the practice leave a message for patient? Yes No Preferred Language: _____

Identifying Information:

Ethnicity/Race (please circle): White, Hispanic Origin White, Not of Hispanic Origin Black / African-American

American Indian or Alaskan Native Asian or Pacific Islander Other or Mixed Heritage: _____

Primary Care Provider Name/Number: _____

Referring Provider Name/Number: _____

Pharmacy Name/Address/Number: _____

Emergency Contacts:

Primary Contact: _____ Phone: _____ Relationship: _____

Secondary Contact: _____ Phone: _____ Relationship: _____

Financially Responsible Party:

Name: _____ Relationship to Patient: _____

Date of Birth: _____ Address (if different from above): _____

City: _____ State: _____ Zip: _____ Phone Number: _____

Insurance Information:

Primary Insurance: _____ Contract #: _____ Group#: _____

Policy Holder (if different than patient): _____ DOB: _____ SS#: _____

Secondary Insurance: _____ Contract #: _____ Group#: _____

Policy Holder (if different than patient): _____ DOB: _____ SS#: _____

CONSENT TO THE USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION FOR TREATMENT, PAYMENT, RESEARCH, AND HEALTHCARE OPERATIONS

• I understand that my health information may be used and disclosed by Alabama Psychiatry (AP) to carry out treatment, to obtain payment, and to conduct healthcare operations. I understand that AP has a Privacy Policy, which gives a more complete description of uses and disclosures of health information, and which is freely available for me to read. I hereby grant medical personnel of AP permission to release health information acquired over the course of my examination and treatment to the appropriate parties, with all due discretion, when necessary for treatment, payment, healthcare operations, and emergency purposes. Examples of my health information that may be released include clinical findings, diagnosis, assessment, laboratory results, progress notes, psychotherapy notes, treatment recommendations, names of health care personnel, dates of hospitalizations, charges, visits, and any other information that may be related to medical and psychiatric conditions, including drug and alcohol related problems and sexually transmitted diseases. I understand that medical personnel at AP will communicate, on a regular basis, with other treating health care providers. All records are kept confidential and shared only with pertinent personnel involved.

• I understand that I have the right to request restrictions on how health information may be used or disclosed, but that the provider designated is not required to agree to the restrictions requested. I understand that I have the right to revoke this consent in writing, except to the extent that the provider has acted in reliance on the consent. I agree that this consent shall be valid for the duration of my treatment at AP or until rescinded in writing.

Printed Patient Name: _____ Date: _____

Signed (or Responsible Party): _____ Relationship: _____

OVERVIEW OF GENERAL PRACTICE POLICIES

(Please visit our website for a more detailed overview.)

Appointment Policy: An appointment is considered a mutual commitment between you and your clinician, and is subject to personal accountability and responsibility in keeping and managing appointments. A 24 (twenty-four) hour notice is required to reschedule or cancel your appointment to avoid automatic no-show or cancellation fees. Appointments for which you arrive late may be cut short to keep the provider on time. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping up with your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so may result in a fee and rescheduling (if applicable) of the appointment. ***Initials*** _____

Payment for Services: AP will directly bill your insurance company following your visits. Your co-payment, deductibles and balances which may apply, will be collected when you check-in. If we are not billing an insurance company for your service, the full payment is due at the time of service. AP accepts cash, checks, debit/credit cards and money orders. Balances and payment agreements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. More information can be found in the Financial Agreement. ***Initials*** _____

Confidentiality: The clinic may use information in your chart in the process of providing your medical and/or mental health treatment and other services. Disclosure of your medical/mental health information will be limited to your treatment team, including any doctors, nurses, students, and other staff involved in your treatment, in addition to any disclosures required to coordinate services such as lab work and prescriptions. No information will be released about you or your care to anyone outside the office without your consent or a court order, or as otherwise required by law. The only exception may be made if you are suicidal, homicidal, are a threat to yourself or others, and if we fear child/elder abuse or neglect. You will fill out a Release of Information form where you will list any person(s) to whom we may communicate with regarding you, your care, and/or financial matters regarding your account. ***Initials*** _____

Treatment Concerns/Issues: Our office staff will regularly take phone calls and check messages throughout the normal business day. Please allow 48-72 (business) hours for a response, as our providers are not in the office every day. Also, if you are running low on medication or your condition is becoming more severe, please contact our office as soon as you are aware of this, so that we can help you more quickly. If your need is urgent due to safety/crisis issues, please call 911 or go to the nearest Emergency Department for assistance. ***Initials*** _____

Laboratory Policy: It may be medically necessary for your physician to request lab or urine drug screens (UDS) to provide the best possible treatment. It is your responsibility, as our patient, to obtain the requested exams; these tests are a part of your treatment plan. Our office will assist you as much as possible, but testing may require you to visit an outside facility. If you do not obtain the tests within a reasonable time frame, your physician reserves the right to refuse a refill or prescribe further medications until tests are completed. UDSs are performed on patients when necessary. All new patients and patients who are prescribed controlled medications will have an initial UDS and will be subject to monthly UDS after. Any charges that may result from the UDS will be the responsibility of the patient if not covered by the insurance company. ***Initials*** _____

Dismissal: If you are "dismissed" or "fired" from the practice it means you may no longer schedule appointments, get medication refills, or consider us to be your current physician/therapist. You should find a physician/therapist in another practice. You will receive a letter in the mail to your last known physical address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter we will assist you with care. We will forward a copy of your medical record to your new physician when a release is received. Common causes for dismissal (include but are not limited to): failure to keep appointments, frequent no-shows, general non-compliance (failure to follow physician instructions as a part of your treatment plan), physical or abusive language or actions towards staff, and failure to pay your bill. ***Initials*** ___

Consent: I have read and understand these policies in their entirety and agree to abide by these terms. I am also aware that if I have questions about this document, I am encouraged to bring them to the attention of AP. Please indicate your agreement to the terms of this policy by signing below:

Printed Patient Name: _____ Date: _____

Signed (or Responsible Party): _____ Relationship: _____

MEDICAL INFORMATION RELEASE FORM AND NOTICE OF HIPAA

Patient Name: _____ Date of Birth: _____

HIPAA & Consent for use or disclosure of PHI (Protected Health Information):

By signing below, you hereby consent for Alabama Psychiatry to use or disclose information about yourself (or another person for who you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practice for PHI available to you on our website, that has been provided to you, or that is clearly posted at the front desk before signing this consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the front desk, checking new policy postings, or checking the website. By signing, you acknowledge that you have received AP's Notice of Privacy or have the opportunity to obtain a copy, and that you have read and understood the document completely.

You have the right to request that Alabama Psychiatry restrict how PHI is used or disclosed to carry out treatment, payment, or healthcare operations. AP is not required to agree to requested restrictions. However, if AP agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law (HIPAA), and you have the right to revoke this consent, unless we have acted in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the PHI used or disclosed to this consent may be subject to re-disclosure by AP and may no longer be protected under federal law. AP may communicate with the following individuals regarding my condition or course of treatment.

Release of information:

Information is NOT to be released to anyone. ***Initials*** _____

OR

I authorize the release of any information including but not limited to the diagnosis, records, services rendered to me and my claims/financial information, to the individuals listed below (please list name and relationship). ***Initials*** _____

____ Spouse - Name of Spouse: _____

____ Child(ren) – Name(s) of Child(ren): _____

____ Parent(s) – Name(s) of Parents: _____

____ Other – Please Specify: _____

Coordination of care:

Please list the names and phone numbers of other physicians from whom you are receiving care. AP strives to provide accurate and coordinated care and therefore requests your permission to speak with any other providers who may also be treating you.

Name: _____ Phone Number: (_____) _____-_____

Name: _____ Phone Number: (_____) _____-_____

Name: _____ Phone Number: (_____) _____-_____

Please indicate by signing below, that I have read the above information and agree to the contents, including "Coordination of Care" with my physicians.

Printed Patient Name: _____ Date: _____

Signed (or Responsible Party): _____ Relationship: _____

Obtained copy of HIPAA Policy (please initial by one) ____ Requested ____ Declined

NO-SHOW/MISSED APPOINTMENT AND LATE CANCELLATION POLICY

It is your responsibility as the patient to attend all scheduled appointments. If, for some reason, you are unable to make your appointment, it is **YOUR RESPONSIBILITY TO CANCEL** the appointment with a member of our staff, 24 (twenty-four) hours prior to the scheduled appointment time. For New Patient Appointments, we require a 3-day notice to cancel or reschedule. Messages are acceptable and can be left during normal business hours.

If you do not provide at least 24 hours' notice (3 days for New Patient Appointments), you will be charged a No-Show fee of $50 for each appointment missed. In addition, if you are more than 15 minutes late to your appointment, this will be considered a No-Show and you will be charged the No-Show fee. Subsequent missed appointments will result in additional $50 charges and possible dismissal from the practice.

Patients who have arrived on time will be seen ahead of those who arrive late to their appointment. If you arrive late, we reserve the right to abbreviate or reschedule your visit upon your arrival. This helps us reduce wait times for patients.

No-Show fees will be added to your patient due statement. These fees must be paid at your next scheduled appointment. Insurance will not be billed for these charges and they are the sole responsibility of the patient. The fee(s) may only be waived by the Practice Manager and are decided on a case by case basis.

Please indicate your agreement to the terms of this policy by signing below. This acknowledges that you have read, understood, and agreed to our policy.

Printed Patient Name: _____ DOB: _____

Signed (or Responsible Party): _____ Date: _____

MEDICATION REFILL POLICY

During your course of treatment at Alabama Psychiatry, you may be prescribed medications. It is your responsibility as the patient to notify your physician if you need a refill at your scheduled appointment. If you are overdue for a follow-up, or missed your last scheduled follow-up, we will require an appointment prior to refilling medications. Failure to show or frequently cancelling your appointments at which your medications would be refilled, without rescheduling, is considered non-compliance with our office policies and you may be dismissed from the practice.

Please note that no refills will be called in after-hours or on the weekends or on holidays. You must attend all scheduled appointments with your physician if you wish to continue obtaining prescriptions for your current medications. If you have failed to follow up appropriately, it is at the physician's discretion how to handle your refill requests.

You may email the nurse regarding medications, refills, and concerns, which will then be discussed with the provider. The nurse's email address is nurse@rrpa.us. Please allow 48-72 hours for a response. If you are running low on your medication, PLEASE CONTACT OUR OFFICE AS SOON AS POSSIBLE, to provide adequate time for us to handle your request. Please note that our office will pull in your prescription history via the SureScripts portal.

Controlled substances (including, but not limited to, Adderall, Vyvanse, Concerta, etc.) will be issued by your clinician at their discretion. Since these medications are highly regulated, you must provide a signature when picking them up. Prescriptions for controlled substances or lost medication will not be rewritten. In addition, patients taking controlled substances will be subject to random urine drug screening and pill/capsule/film counts.

By signing below, you acknowledge that you have read, understood, and agreed to our policy.

Printed Patient Name: _____ DOB: _____

Signed (or Responsible Party): _____ Date: _____

INFORMED CONSENT FOR TREATMENT

I agree and consent to participate in psychiatric and therapeutic services offered by a provider at AP. I understand that I am consenting and agreeing to services provided within the scope of the license, certification, and training of my provider or another provider who is directly supervised within the practice. I understand that I may see another provider with the practice, if my provider is unavailable.

If the patient is unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment or I am legally authorized to initiate consent and treatment on behalf of this individual. I agree to provide a copy of my custody and/or guardianship papers if requested. I understand that I, as a patient or legal guardian, have the right to consent or refuse treatment or habilitation at any time. My refusal of treatment or habilitation will not be used as grounds for discharge or potential discharge unless the advised treatment is the only option available at this practice.

Printed Patient Name: _____ Date: _____

Signed (or Responsible Party): _____ Relationship: _____

FOR OFFICE USE, ONLY: I attest that I have provided ample time for the patient to read this information and have answered all patient questions regarding consent for treatment or have directed the patient to his or her provider for further clarification. Witness Signature: _____ Date: _____

CONTROLLED SUBSTANCE AGREEMENT

This Agreement is to prevent misunderstandings about the medications you may be prescribed as a part of your treatment plan as a patient of Alabama Psychiatry (AP). Controlled substance medications (e.g., benzodiazepines, opioids, amphetamines, and anti-anxiety medications) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. As a patient of AP, you agree and understand the following (initial each section):

_____ 1) I am solely responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if "I run out early" I understand that this medication will not be replaced. In the event of a "theft," the physician MUST be provided with explicit proof with direct evidence from authorities (e.g., a police report). I understand and agree I may not share, sell, or permit others, including spouse or family members, to have access to any controlled substance(s) that have been prescribed to me.

_____ 2) Refills of controlled substance medications:

a) Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night or on weekends or holidays.
b) I am solely responsible for taking the medication as prescribed and for keeping track of the amount remaining.
c) I understand and agree to keep all appointments. If I miss an appointment, I understand that all follow-up appointments must be made and kept before any prescriptions will be refilled and/or changed, as ALL prescriptions will be issued ONLY during a scheduled appointment with my physician.

_____ 3) I understand and agree to comply with random urine and/or blood drug screens/tests and possible pill counts at every appointment with my physician's office or at a lab designated by my physician and that I will be responsible for the cost of these screens or tests. These are to ensure proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.

_____ 4) I further understand that if I violate this controlled substance agreement due to noncompliance of medical directions, including (but not limited to) failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, then I may be subject to dismissal from AP.

_____ 5) I agree to conduct myself in a courteous manner while in the office. I agree to not sell, share, or give any of my medication(s) to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

_____ 6) I understand and agree that always I will make my physician aware of all medications I am taking including controlled substances and over-the-counter medications prescribed by other providers. I understand it is unlawful to attempt to obtain prescriptions for controlled substances from multiple providers, and will not seek prescriptions for controlled substances from any other physician, healthcare provider, or dentist.

_____ 7) I understand that altering any prescription is a FELONY offense and that suspicion of this behavior will be reported to the proper authorities. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without consulting my doctor.

_____ 8) I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine, and other addictive substances.

_____ 9) I understand and agree to fill ALL my controlled medications at an in-state (AL) pharmacy. I will list my pharmacy of choice below and understand that I must utilize this pharmacy. If at any time, I choose to change my pharmacy, I will notify AP and complete this information again.

PHARMACY NAME: _____ **PHONE NUMBER:** _____

_____ 10) I give my consent for my physician or his designee to contact all my physicians and pharmacies to assure I follow this Agreement. The office will also check the State of Alabama Prescription Drug Monitoring Database (ALPDMP) to monitor prescriptions filled. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescriptions illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of AP regarding the controlled substance(s) my physician is prescribing. I have been given an opportunity to ask questions about my condition, alternative forms of treatment, risks of non-treatment, the medications instructions for use, risks and hazards, and all other provisions in this Agreement. All my questions have been answered to my satisfaction.

Patient Signature: _____ Printed Name: _____ Date: _____

Physician Signature: _____ Date: _____

Alabama Psychiatry

FINANCIAL POLICY

Alabama Psychiatry wants to assist you in the financial management of our relationship. Please be advised that this is not an all-inclusive list. Benefit verification will be provided as a courtesy and is not a guarantee of payment. Be assured that we will be ethical and fair concerning any billing or collection concern you may have. If you have any questions, please speak with our Business Office at 334-239-2622.

Participating Provider Plans

- Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
- Our billing department will gladly submit your claims and assist you in getting your claims paid promptly. We file claims to your insurance as a courtesy. We will attempt to file a claim up to 3 times, if there is no response from your carrier then the balance will be turned to patient responsibility.
- The patient is responsible for presenting all current available insurance cards at the time of service. It is your responsibility to notify us of ANY changes in your insurance information, insurance cards or coverage.
- The patient is responsible for co-pays, deductibles, and co-insurance at the time of service. (If you have Medicare and a supplemental we will file Medicare and supplemental; then transfer balance to you after your supplemental has paid on claim. If you do NOT have a supplemental insurance, you will be responsible for the 20% of Medicare allowable for each service plus any deductible.)
- The patient is responsible for knowing their policy coverage, deductibles, co-insurance, etc.

Non-Participating Plans

- The patient is responsible for all "out of network" patient responsibility at time of service unless other payment arrangements have been made. This would include any co-insurance, deductible, and the difference between carriers allowable and our standard fee.
- Our billing department will gladly file your insurance as a courtesy, but cannot guarantee acceptance or payment of the claim.
- Acceptance of co-pay DOES NOT constitute participation with your insurance carrier NOR will it be deemed as payment in full for services rendered. Your claim will be processed by your carrier and you will be billed for the balance on your account.

Self-Pay

- Patients with no insurance coverage or patients who fail to provide proof of insurance will be considered self-pay.
- Self-Pay patients will sign this form indicating that they have NO health insurance.
- Payment is due at time service is rendered and you will be required to arrange a payment plan at the time of your initial visit.
- Should disability and/or Medicaid benefits become effective, it is imperative that you notify our office timely.

Collections

- Collection notices begin if the balance has not been paid within 60 days.
- All unpaid balances will be sent to an outside collection agency after all practice efforts have been exhausted. This will result in a negative credit rating. All reasonable attorney fees and collection cost will be the patient's responsibility in the event of default of payment. A collection fee will be charged to patient account for outside collection activity.

Return Check Fee

- A fee of $30.00 (or amount allowed by law) will be charged to patient account for Return Checks.

Missed Appointment Fee

- If you are unable to keep your scheduled appointment, kindly provide notice within 24 hours of the scheduled appointment. With the high volume of missed appointments, AL Psychiatry has been forced to implement a No Show/Missed Appointment Fee to all patients. Unfortunately, insurance does not pay for missed appointments and we do not bill insurance companies for missed appointments. The missed appointment fee is the responsibility of the patient, regardless of your insurance carrier. **You will be billed the following rates for missed appointments: Routine Office Visits - $50.00.**

Outside Laboratory Test

- AL Psychiatry may order laboratory test that cannot be completed in our facilities. In this situation, blood is drawn and sent to an outside lab for testing. When this occurs, our patients may receive a separate bill from the outside lab for test performed. In the event you are a self-pay patient, our office may be required to add additional charges to your account to cover the expenses incurred by the outside lab for its testing.

PATIENT AUTHORIZATION

I, hereby consent to the rendering of medical care, which may include routine diagnostic procedures, laboratory testing, medical and/or surgical procedures performed by authorized physicians and/or staff members of Alabama Psychiatry. I understand terms are for services rendered. I will be responsible for all charges incurred by me and/or my dependent(s). Should collection proceedings become necessary, I agree to pay all costs of collection, including a reasonable attorney's fee. I hereby assign to and authorize payment directly to Alabama Psychiatry. All benefits payable under the terms of any insurance policy listed above. If insurance is filed by AL Psychiatry, I realize the insurance benefit may not pay the entire bill and agree to pay the difference or the entire bill, if necessary. I authorize the release of any medical information necessary to process my insurance claims or to continue my medical care. I acknowledge that I have been provided access to the Notice of Privacy Practices of Alabama Psychiatry. AL Psychiatry's Notice of Privacy Practices explains to me use and disclosure of my protected health information (PHI).

Signature Patient/Responsible Party _____ **Date:** _____

Revised: 4/2018

Medicare Part B

Extended Patient Signature Authorization

Provider's Name: RIVER REGION PSYCHIATRY ASSOCIATES, LLC d/b/a ALABAMA PSYCHIATRY

Provider's Address: 233 WINTON BLOUNT LOOP
MONTGOMERY, AL 36117

7125 UNIVERSITY COURT
MONTGOMERY, AL 36117

208 WEST FORT WILLIAMS STREET
SYLACAUGA, AL 35150

333 BUSINESS CIRCLE
PELHAM, AL 35124

2436 E. UNIVERSITY DRIVE, SUITE 2202
AUBURN, AL 36830

PATIENT'S NAME [Print]: _____

Payment for services rendered is to be made as follows:

"I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I also understand that I am responsible for the deductible, coinsurance, and any non-covered services as determined by Medicare."

_____ _____
Patient or responsible party (printed) signature Date

_____
Relationship to patient