Dothan Behavioral Medicine Clinic

PATIENT REGISTRATION FORM
(Please Print)

Today's date: Doctor/Clinician to be seen:

PATIENT INFORMATION

Patient's last name: ______________ First: ______________ Middle Initial: ______

Is this your legal name? If not, what is your legal name? ______________ D.O.B: __________ Age: ____ Sex: ____

Street address: ______________ Social Security no.: ______________ Home phone: __________

P.O Box: ________ City: ______________ State: __________ Zip code: ______________

E-mail address: ______________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is this patient cover by insurance? ______________________________

Please indicate primary insurance: ______________________________

Subscriber #: ______________________ Group #: ______________________

Subscriber's name: ______________ Subscriber's S.S. no.: ______________ D.O.B: ______________

Patient's relationship to the subscriber: ______________________________

COLLECTION AGREEMENT

IF YOUR ACCOUNT SHOULD BECOME DELINQUENT MORE THAN 60 DAYS, IT WILL BE TURNED OVER TO A COLLECTION AGENCY. A COLLECTION FEE OF 33% AND 18% INTEREST FEE WILL BE ADDED TO THE BALANCE ON ACCOUNT.

____

Patient/Guardian Signature Date Witness Date

IN CASE OF EMERGENCY

Name of local friend or relative (not living at the same address): Relationship to patient: Cell phone no.:

____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Dothan Behavioral Medicine Clinic or insurance company to release any information required to process my claims.

____

Patient/Guardian Signature Date

With your signed consent: Treatment: Means the provision, coordination, or management of your medical and clinical health care, including consultations between your Dothan Behavioral Medicine Clinic staff providers, Follow-up: Means contact made after the Initial Evaluation for follow-up studies and Progress updates. With Your Signed Authorization: Means activities we undertake to obtain reimbursement for health care provided for you, including determinations of eligibility and coverage and other utilization review activities.

____

Patient/Guardian Signature Date Witness Date

STATEMENT OF UNDERSTANDING REGARDING CONFIDENTIALITY

We are proud that you have decided to choose Dothan Behavioral Medicine Clinic. There are several things we want you to know before we begin providing quality services to you. Personal problems are sometimes difficult to talk about. For this rea son, assurance of confidentiality is extremely important. We take every precaution in protecting the confidentiality of your visit with us and we hope that you will do the same. WE DO NOT DISCUSS YOUR SITUATION WITH ANYONE EXCEPT FOR REASONS CITED BELOW, UNLESS YOU GIVE US WRITTEN PERMISSION TO DO SO. THERE ARE SEVERAL LIMITATIONS TO CONFIDENTIALITY THAT ARE BEYOND YOUR CONTROL:

1. If we learn about child abuse or abuse of disabled adults, we are required by law to report it to the proper authorities.

2. If, in our judgment, a client is dangerous to himself or others (suicidal or homicidal), we will disclose information in order to help protect the person from harm. 3. If we are required to present records to comply with a court order, it is our legal responsibility to comply. 4. In providing services to adolescents, there may be limits in the confidentiality of informatio n between parent and adolescent. THIS PROVIDES A SAFE AND SECURE OPPORTUNITY FOR YOU TO DISCUSS PERSONAL PROBLEMS WITH US. WE WILL HELP YOU WITH AN ASSESSMENT OF YOUR PERSONAL PROBLEMS AND THEN WILL HELP YOU DEVELOP A PLAN OF ACTION, WHICH WILL INPRIVACY NOTICE CLUDE OUR TREATMENT RECOMMENDATIONS.

PRIVACY NOTICE

This notice describes the type of information we gather about you, with whom that information may be shared and the safeguards we have in place to protect it. You have the right to the confidentiality of your health information and the right to approve or refuse the release of specific information except when the release is required by law. OUR PLEDGE REGARDING YOUR HEALTH INFORMATION: We understand that information about you and your health is personal. Protecting health information about you is important. We create a record of care and services you receive. We need this record to provide you with consistent quality care and to comply with regulatory agencies. This notice applies to all of the records of your care generated by the Dothan Behavioral Medicine Clinic. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information. USES AND DISCLOSURES OF YOUR HEALTH INFORMATION: We will use and disclose elements of your protected health information (PHI) in the following ways:

With Your Signed Consent: Treatment: Means the provision, coordination, or management of your medical and clinical health care, including consultations between your Dothan Behavioral Medicine Clinic staff providers. Follow-up: Means contact made after the Initial Evaluation for follow-up studies and Progress updates. With Your Signed Authorization: Means activities we undertake to obtain reimbursement for health care provided to you, including determinations of eligibility and coverage and other utilization review activities.

Progress Reporting: Means activities we undertake to keep school officials (or any other persons directly related to the care of your child/family member) informed of his/her progress in regards to treatment. Authorization is also required for any disclosure of your protected health care information to any person(s) or agencies. Except for the special situations set forth below, we will not use or disclose your protected health information for any other purposes unless you provide written authorization. You have the right to revoke that authorization at any time, provided the revocation is in writing, except to the extent that we have taken action in reliance on your authorization.

Special Situations:

Public Health Risks: We may disclose protected health information for public health activities such as: (1) Prevention and control of disease; and/or (2) To report child abuse or neglect. Law Enforcement: We may release privileged health information if asked to do so by a law enforcement individual: (1) In response top a court order; and/or (2) About criminal conduct on our premises. Serious Threats: As permitted by applicable law and standards of ethical conduct, we may disclose protected health information if we, in good faith, believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a person or the public. Emergency: We may disclose protected health information in a care situation where you are incapable of giving consent. Military: If you are a member of the armed forces, we may release information about you as required by military authorities.

IF patient is a Minor fill out only Section B

**under current law, this means a single individual under 19 years of age and a married individual less than 18 years of age*

Section A

I have read, agreed to and received a copy of this consent.

Patient's Signature   Date

Patient's Name Printed

Signature of person Obtaining Consent

Section B This section is to be signed by Legal Guardian Only!

I have read, agreed to and received a copy of this consent.

Parent or Guardian's Signature   Date

Parent or Guardian's Name Printed

Patient's Name Printed

Signature of person Obtaining Consent

Authorized person(s) allowed to bring patient to Clinic (please print name(s)

Dothan Behavioral Medicine Clinic

Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act 1996 requires that the health care providers give patients a copy of the office Notice of privacy Practices and make a good faith effort to obtain an acknowledgement of receipt of same. You may refuse to sign this acknowledgement form.

By signing this form I confirm I have received a copy of the Notice of Privacy Practices.

(Office use only) Case Number: ______________________

Print Name: ______________________

Sign Name: ______________________

Relationship to patient: ______________________

Date: ______________

Written Acknowledgment was not obtained

- ☐ Patient refused to sign
- ☐ Emergency situation
- ☐ Unable to communicate with patient
- ☐ Other ______________________

______________________ (Witness Signature) ______________________ Date

Note: Future changes in federal and state law may mandate revisions

Coroners: We may release information to a coroner or medical examiner for identification or to determine the cause of death. National Security: We may release information about you to authorized officers so they may provide protection to the president, as well as other national security activities authorized by law.

YOUR RIGHTS:

1. You have the right to inspect and request a copy of the health care information that may be used to make decisions about your care. Usually this Includes medical and billing records, but may not include psychotherapy notes. To inspect and request a copy of your health care information, you must submit your request in writing to: Dothan Behavioral Medicine Clinic, Attn: Medical Records Department, 408 Healthwest Drive Dothan, AL. 36303. If you request a copy of the information, we will charge a fee for the cost of copying, mailing, or other supplies associated with your request.

2. If you feel that health care information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Clinical/Medical Director. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your the person or entity that created the information is no longer available to make the amendment; (2) is not part of the health information kept by Dothan Behavioral Medicine Clinic; or (3) is accurate or complete.

3. You have the right to request an "account disclosure." This is a list of the disclosures we made of health information about you. To request this list or accounting of disclosures, you must submit your request in writing to the Clinical/Medical Director. Your dates may not include dates before April 14, 2003.

4. You have a right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. To request restrictions, you must make your request in writing to the Clinical/Medical Director. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

5. You have the right to request that we communicate with you about health care matters in a certain way or at a certain location. For example, you can ask that we only contact you at home or by mail.

CHANGES TO THIS NOTICE: We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice. This notice will contain on every page, in the bottom left hand corner, the effective date.

COMPLAINTS: If you believe your privacy rights have been violated, you may file a complaint with Dothan Behavioral Medicine Clinic. To file a complaint with DBMC, contact our Privacy Officer at the address and phone number below. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

PRIVACY OFFICER: Tami Johnson, Chief Privacy Officer, 408 Healthwest Drive Dothan, AL 36303 334-702-7222

OTHER USES OF HEALTH INFORMATION: Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, thereafter we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we have provided to you. Dothan Behavioral Medicine Clinic / HIPPA PRIVACY NOTICE: 04142004 FORM 1002-A