WELCOME TO BEHAVIORAL SCIENCES OF AL, INC (BSofA) Trinity Counseling Center

How did you hear about our office? _____ Today's Date _____ Provider _____

PATIENT INFORMATION

Patient's Name _____ DOB_____ /_____ /_____ Age _____ M/F_____

Address _____City_____ State _____ Zip _____

SS #_____/_____/_____ Marital Status_____ Email Address _____

Primary #(_____)_____Alternate #(_____)_____ Work #(_____)_____
OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___

If Employed/Employer_____ OR If Student/School_____

INDIVIDUAL(s) WE MAY SPEAK TO ABOUT YOUR BILL, INSURANCE, MEDICATION and APPOINTMENTS

_____ _____ _____

INFORMATION: PARENT / GUARDIAN / SPOUSE OF PATIENT (if applicable)

Name _____ DOB_____ /_____ /_____ M/F_____

Address _____ City _____ State _____ Zip _____

SS #_____/_____/_____ Marital Status_____ Email Address _____

Primary #(_____)_____Alternate #(_____)_____ Work #(_____)_____
OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___

Relationship to Pt _____ Employer_____

RESPONSIBLE PARTY INFORMATION Please complete if someone other than those listed above is responsible for payment

Name _____ DOB_____ /_____ /_____ M/F_____

Address _____ City _____ State _____ Zip _____

SS #_____/_____/_____ Marital Status_____ Email Address _____

Primary #(_____)_____Alternate #(_____)_____ Work #(_____)_____
OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___ OK TO LEAVE MSG Y___ N ___

Relationship to Pt _____ Employer_____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address_____ City: _____ State: _____

Zip_____

Home phone (____)_____ Work phone (_____)_____ Cell phone (_____)_____

FINANCIAL STATUS (check one)

_____ Self Pay – I will pay each session and related services in full. I do not have insurance, my insurance does not cover providers at this office, or I will be filing my own insurance.

_____ If applicable, Behavioral Sciences will submit claims to my insurance company on my behalf and I will be responsible for charges not paid by my insurance company. I understand that I may be required to pay for my session(s) in full (some exceptions apply) and that any co-payments and/or deductibles are due at the time of service to avoid a billing fee. I will provide information necessary for BSofA to file my insurance claims.

IF APPLICABLE, PLEASE COMPLETE INSURANCE INFORMATION ON BACK OF PAGE

_____ _____
Signature Date

_____ _____

Signature Date

INSURANCE INFORMATION (IF APPLICABLE) (Behavioral Sciences of AL, Inc. BSofA)

PLEASE BE AWARE THAT SOME INSURANCE PLANS FOR MENTAL HEALTH COVERAGE RQUIRE THAT YOUR VISITS BE AUTHORIZED IN ADVANCE OF YOUR APPOINTMENT AT BEHAVIORAL SCIENCES OF AL, INC. HAVE YOU CONTACTED YOUR INSURANCE COMPANY TO SEE IF THIS IS REQUIRED? YES _____ NO _____

IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE CARRIER TO DETERMINE COVERAGE AND PROVIDE US WITH YOUR INSURANCE INFORMATION.

CLAIMS REMAINING UNPAID AFTER 90 DAYS BECOME DUE IMMEDIATELY

PRIMARY INSURANCE COMPANY_____ Employer_____

Policy Holder Name (as it appears on Ins card)_____ Relationship to Pt_____

Address _____DOB _____ /_____ /_____ SS # _____ / _____ / _____

SECONDARY INSURANCE COMPANY _____Employer_____

Policy Holder Name (as it appears on Ins card) _____ Relationship to Pt_____

Address (if different) _____DOB _____ /_____ /_____ SS # _____ / _____ / _____

I authorize BEHAVIORALSCIENCES OF AL, INC and its associated providers to release any psychological, medical, or other information necessary to process insurance claims for services and to receive payment for claims filed.

_____ _____
Signature Date

_____ _____
Signature Date

CONFIDENTIALITY AGREEMENT

Thank you for selecting Behavioral Sciences of AL, Inc. to help you during this time in your life. As you know, the counseling environment requires discussion and revelation of sensitive information. We want you to know that any information from your records and sessions will be kept confidential. We will need your written permission to release any information regarding your relationship with us to anyone other than Behavioral Sciences of AL, Inc. staff. There are some legal exceptions to the issue of confidentiality and we want to be sure you understand them. We are required by law to break our confidentiality agreement with you when:

1. We believe a client is in danger of harming himself or herself.
2. A client makes a threat against a readily identifiable victim.
3. The abuse of children, elderly persons, and disabled/incompetent individual is known or reasonably suspected.
4. A judge orders the release of the information contained in a client's file.
5. The information is necessary to defend against a malpractice suit by client.
6. The client is examined pursuant to a court order.
7. The validity of a will of a former client is being contested.
8. The client is involved in litigation and has claimed mental/emotional damages.
9. The insurance company paying for services exercises their right to examine all records. Also, please note that insurance companies require a diagnosis of a mental disorder (e.g. depression, panic disorder, etc.) before they will reimburse clients. As a result, some clients choose not to file for reimbursement.

Please indicate your understanding of this agreement by signing below. If you have any questions, your counselor will gladly discuss the issue with you.

I understand and agree to these conditions, and will not hold the counselor or Behavioral Sciences of AL, Inc responsible for releasing information under these conditions.

Signature:_____ Date:_____

Signature:_____ Date:_____

Parent/Guardian:_____ Date:_____
(If client is under the age of 14)

RELEASE OF INFORMATION

For continuity of care it may be necessary for Behavioral Sciences of AL, Inc. (BSofA) to communicate with your primary physician / pediatrician, the referring physician and/or your other professional at BSofA.

NAME OF PRIMARY CARE PHYSICIAN / PEDIATRICIAN _____

Address _____

Phone Number _____

By signing below I authorize communication and understand that I am free to revoke this authorization at any time.

Signature:_____ Date:_____

Parent/Guardian:_____ Date:_____
(If client is under the age of 14)

Symptom Checklist

Name:_____ Today's Date:_____

PLEASE PUT A CHECKMARK NEXT TO THE SYMPTOMS YOU HAVE BEEN EXPERIENCING

SLEEP PROBLEMS
___Difficulty falling asleep
___Early morning waking
___Waking during the night
___Feel tired when waking
___Increase in dreams
___Unpleasant dreams
___Excessive sleep

CHANGES IN
___Energy level
___Weight ____lbs: lost/gained
___Health
___Sexual interest
___Sexual performance
___Appetite

FEELINGS OF
___Anxiety
___Tiredness
___Boredom
___Lack of interest
___Sadness
___Depression
___Despair
___Worthlessness
___Helplessness
___Emptiness
___Rage
___Tension
___Loneliness
___Guilt
___Hopelessness

CONFLICT WITH
___Spouse
___Family member
___Other loved one

EXPERIENCE OF
___Vivid dreams
___Nightmares
___Hearing voices
___Seeing visions
___Being out of body

THOUGHTS OF
___Harming yourself
___Harming others

RECENT HISTORY OF
___Nausea/vomiting
___Diarrhea
___Sweating
___Chest pain
___Dizziness
___Headaches
___Trembling
___Lower back pain
___Dry mouth
___Shortness of breath
___Palpitations
___Rapid breathing
___Head injury
___Loss of consciousness
___Loss of memory
___Confusion
___Seizure
___Bleeding
___Swollen joints
___Numbness, tingling
___Paralysis
___Flashbacks
___Blackouts

DIFFICULTY WITH
___Short attention span
___Carelessness or sloppy work
___Listening when spoken to
___Following through on instructions
___Organizing tasks or activities
___Avoiding homework or paperwork
___Losing things at home or school
___Forgetfulness in daily activities
___Fidgeting or squirming in seat
___Playing quietly
___Talking excessively
___Speaking out of turn
___Waiting for others
___Interrupting or intruding on others

PROBLEMS WITH
___Arguing a lot
___Lying
___Stealing
___Losing temper
___Avoiding people
___Spending/finances
___Sexual behavior
___Gambling
___Eating
___Fighting
___Increased drinking
___Destroying things

FEAR OF
___Loss of control
___Death
___Being alone
___Places/situations
___Objects or animals
___Cancer
___AIDS
___Being possessed
___Being insane

Behavioral Sciences of AL, Inc. (BSofA)
OFFICE POLICIES

In order to provide the highest quality of service to you, we ask that you be aware of our office policies.

- Please notify our office as soon as possible if you are unable to keep your scheduled appointment. We do not overbook – your appointment time is specifically for you. If you arrive late, you will be asked to reschedule your appointment. We are generally able to keep to our schedule, but sometimes delays happen, we apologize in advance if you experience one.

- We offer to give you a courtesy reminder call 2 business days before your scheduled appointment. If we do not reach you at the number you instructed us to call, we will leave a message provided your voicemail is active and receiving messages. This is a courtesy only, it is your responsibility to arrive on time for & keep your scheduled appointment. A fee will be charged for missed appointments and appointments not cancelled or changed with 24 hours advance notice. If you call during non-business hours, you will be offered an option to leave a message. (256) 883-3231.

- For your convenience we accept cash, check, debit cards, and most major credit cards, and we accept payments made by phone. Payment for services is due at the time they are administered. If special financial arrangements are made for future care or there is a balance left unpaid due to insurance, your payment will be due monthly, by the 8th of the month. If you are unable to fulfill your payment obligation for any reason, please contact the office so that we are aware of the problem. We will gladly work with you if we are made aware of the circumstance. Consistent monthly payments may help to avoid additional charges and delinquent status. Delinquent accounts will be turned over to a professional collection agency with additional collection fees added.
  A $35.00 service charge will be added to all returned checks; a $10.00 billing fee will be added to unpaid balances over 30 days old. (payment is due at the time of your appointment) It is my responsibility to remit payment for any amount not paid by my insurance company 120 days after service is provided.

- There will be a charge to process medication requests without appointments: lost prescriptions/same day refills or if you have cancelled, missed or did not schedule a follow up visit at your last appointment. Please allow at least 3 business days for prescription refill request; in most cases we do not authorize refill requests called in during non-business hours, or if you miss or cancel your scheduled follow up visit. Messages left will be checked the next business day when our office reopens. We do not accept refill requests from your pharmacy.

- There will be a charge to complete forms (including FMLA and disability), which is not billable to your insurance company.

- Additional Charges: Testing fees vary and are <u>not covered by most insurance carriers; it is your responsibility to check with your insurance company regarding coverage</u>. If you have been referred for testing, a testing estimate will be provided for your review and signature indicating financial responsibility. Please review the estimate carefully and feel free to inquire about the tests suggested and the cost of those tests.

- Fees for non-emergency phone calls, phone consultations, letters or reports, travel time to and from consultations and other professional services will be billed at the professional's hourly rate.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ THE ABOVE INFORMATION AND AGREE TO THE OFFICE POLICIES AT BEHAVIORAL SCIENCES OF AL, INC

_____ _____

Signature Date

_____ _____

Signature Date