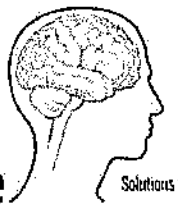
Demographics Intake



BEHAVIORAL SCIENCES OF ALABAMA

Solutions for ADHD, OCD, anxiety and life's many challenges

Name:_____

Address:_____

City:_____ ST:____ Zip code:_____

Preferred Phone:_____

Secondary Phone:_____

Email:_____

Date of Birth:_____

Marital Status:_____

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HIPAA Privacy Rule of Patient Authorization Agreement Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I understand that as part of my healthcare, this Practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this Practice's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this Practice's Notice of Information practices prior to signing this consent;
- that this Practice reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this Practice is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this Practice has already acted in reliance thereon.

_____

Signature of Patient or Legal Representative Witness:

Patient Name: _____

Behavioral Sciences of AL, Inc (BSofAL) · 810 Shoney Dr · Suite 120 · Huntsville, AL 35801 · (256) 883-3231 · fax (256) 883-9577
www.behavioralsciencesofalabama.com

Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from
my pharmacy, my health plans, and my other healthcare providers.

_____
Signature of Patient or Legal Guardian

Patient Name: _____

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Telehealth Waiver

We are currently offering appointments by phone or video. We use Zoom software for our telehealth visits, which is a secure platform designed to ensure that your privacy is protected. Our providers can confirm your information is secure and our efforts remain HIPAA compliant on our end. With this being a virtual visit, we cannot confirm privacy on your end from your home. We will make sure to share this with you at each visit and ask if you would like to proceed before continuing your virtual appointment.

We do not allow sessions to be videotaped, recorded, or documented by any other means without the provider's consent. If there is a release of information and all participants agree, this can be discussed with the provider prior to session.

Only patients and parties involved in the session should be in attendance.

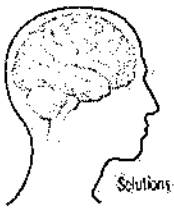
If any violations of HIPAA or above policies are violated by the client the office reserves the right to review the situation and may result in termination of care.

If you are filing for insurance reimbursement or coverage, please check with your insurance company to confirm that telemedicine services are covered.

_____

Signature of Patient or Legal Guardian

Patient Name: _____



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Behavioral Sciences of Alabama, Inc.
Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Behavioral Sciences of Alabama to use and disclose my protected health information (PHI) to perform treatment, payment and health care operations (TPO).

With this consent, the Practice may call me or email me to my home or other alternative location and leave a message by voice, email or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and anything pertaining to my clinical care, including laboratory test results.

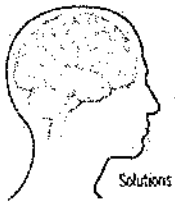
With this consent, the Practice may mail to my home or other alternative location any items that assist the practice in performing TPO, such as appointment reminder cards, patient statements and anything pertaining to my clinical care as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow the Practice to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the Practice has already made disclosures upon my prior consent. If I do not sign this consent, or later revoke it, the Practice may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

Patient Name: _____



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Behavioral Sciences of AL, Inc. (BSofAL)

Office Policies

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

******Please read each section and sign below******

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.

As a courtesy we offer to give you a reminder before your scheduled appointment. We offer phone call, text or email. **Please note that text and email are not secure.** If you request a phone call reminder and we do not reach you at the number you provided, we will leave a message provided your voicemail is active and receiving messages. If you see a missed call from our number, please check your voicemail before you call the office. This is a courtesy only. It is your responsibility to arrive on time for and keep your scheduled appointment. If you call during non-business hours, you will be offered an option to leave a message. (256) 883-3231.

Cancellations/Missed Appointments:

At times it may be necessary to cancel an appointment. Changes or cancellations must be made at least 24-48hrs in advance. Missed appointments or late cancellations made less than 24hrs in advance will be charged a $25 fee. If another occurrence happens that fee will go to $50, and a third incident will be $75 and will remain at $75 moving forward. Behavioral Sciences of Al, Inc. reserves the right to; discharge a client based on continued missed sessions, cancel upcoming appointments, and/or may require prepayment for future appointments.

Payment for Services:

Payment for services is due at the time of service. For your convenience we accept cash, check, most major credit cards/debits cards, and have a patient portal for online payment. Special financial situations and payment plans must be discussed prior to an appointment with the billing office. Billing fees may be incurred if payments are not paid promptly, and neglect of payment on an account may result in collections.

Fees:

There will be a $30.00 fee to process medication requests without appointments (you can pay by phone at the time of the refill request). 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; 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 *minimum* fee of $35.00 to complete forms, letters, etc. (including FMLA and disability), which is not billable to your insurance company.

Testing: Testing fees vary; we do not file insurance for testing. You are responsible for payment, and we will provide you with information needed to check with your insurance company regarding coverage. If your professional has recommended testing, a cost estimate will be provided for your review and signature indicating your financial responsibility, prior to scheduling tests. Please review the estimate carefully and feel free to inquire about the tests suggested and the cost of those tests.

Additional Charges: *Books:* prices vary by book; payment is due upon receipt of the book. *Fees for non-emergency* phone calls, emails, phone consultations, 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 _____

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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 professional will gladly discuss the issue with you.

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

Signature _____Patient Name: _____

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

CONTINUITY OF CARE (PROFESSIONAL COMMUNICATION)

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

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

Signature _____
Parent/Guardian _____

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Insurance Information

Please note this information will be used if your provider will be filing for your insurance or in the event it is needed for referrals or medication prior authorizations. Not all providers file for all insurance carriers. This will be verified in your intake phone call with the scheduler.

Primary Insurance:

ID Number:

Group Number or Enrollment Code:

Employer:

Subscriber's Name:

Subscriber's DOB:

Relationship to patient:

Secondary Insurance:

ID Number:

Group Number or Enrollment Code:

Employer:

Subscriber's Name:

Subscriber's DOB:

Relationship to patient:

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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