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:_____

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: _____

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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.

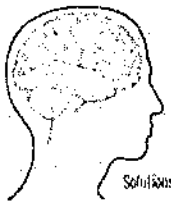
It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your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

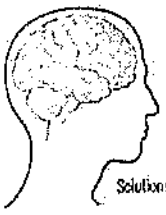
If any violations of HIPAA or above policies are violated by the client the office reserves the right to review the situation and may result in termination of care.

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: _____

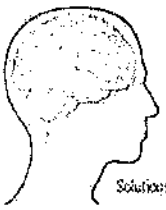
Parent/Guardian (If client is under the age of 14) _____

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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Primary Insurance

Insurance Name :_____

Subscriber/Policy Holder Name :_____

Relationship to patient :_____

Date of Birth of Subscriber :_____

Subscriber Employer :_____

Contract ID/ Member ID :_____

Group Number :_____

Secondary Insurance

Insurance Name :_____

Subscriber/Policy Holder Name :_____

Relationship to patient :_____

Date of Birth of Subscriber :_____

Subscriber Employer :_____

Contract ID/ Member ID :_____

Group Number :_____

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.

PLEASE BE AWARE THAT SOME INSURANCE PLANS FOR MENTAL HEALTH COVERAGE REQUIRE THAT YOUR VISITS BE AUTHORIZED IN ADVANCE OF YOUR APPOINTMENT AT BEHAVIORAL SCIENCES OF AL, INC.

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH INSURANCE INFORMATION, INCLUDING COVERAGE DETERMINATION, NUMBER OF SESSIONS ALLOWED PER YEAR AND ANY OTHER REQUIREMENTS THAT HAVE TO BE MET.

By signing below you are giving BSoAL permission to file for insurance if that is listed on your account as a form of payment for services rendered.

_____

Signature of Patient/ Guardian

810 SHONEY DR
HUNTSVILLE, AL 35801-5450

Phone: (256)883-3231
Fax: (256)883-9577

Dr. Aparna Vuppala

Child Psychiatric Checklist

Name of child:

Rater

Diagnosis (by mental health professional) and Current medications, if any:

Please take a few minutes to report your child's behavior over the past few weeks:

Category A

Fidgets with hands or feet or squirms in seats

Has difficulty remaining seated when asked to do so

Is easily distracted

Has difficulty awaiting turn in games or group acitivites

Blurts out answers to questions before they have been completed

Has difficulty following through on instructions from others; fails to finish things they started

Has difficulty paying attention to tasks or play activities for an extended period of time

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Shifts from one uncompleted activity to another

Has difficulty playing quietly

Talks excessively

Interrupts people or butts into other children's games

Does not seem to listen

Loses things necessary for activites
at school or home

Does dangerous things without considering possible consequences (like running into the road)

Has difficulty organizing work

Needs a lot of supervision

Calls out in class

Excessively runs about or climbs on things

Is always "on the go" or acts as if "driven by a motor"

Category B

Steals things

Runs away from home overnight

Serious lying

Deliberately starts fires

Breaks into someone else's house, building, or car

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Deliberately destroys others' property

Is physically cruel to animals or people

Starts physical fights with others

Breaks important rules that are appropriate for their age

Category C

Loses temper or has temper tantrums

Defies or refuses what you tell them to do

Does things to deliberately annoy others

Blames others for their own mistakes

Is touchy or easily annoyed by others

Is angry or resentful

Swears or uses obscene language

Argues with what you tell them to do

Acts stubborn

Category D

Has unrealistic worries about future events

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Is overly concerned about their own abilities in athletic, academic, or social situations

Complains about physical problems (headaches, upset stomach, etc.) for which there is not apparent cause

Is extremely self-conscious

Has excessive need for reassurance

Is extremely tense or unable to relax

Category E

Is depressed or irritable for most of the day

Shows little interest in (or enjoyment of) pleasurable activities

Recent major changes in appetite or weight

Has difficulty falling asleep or staying asleep

Has low energy level or is tired for most of the day

Feels worthless, guilty, or inferior to others (puts themselves down)

Has recurrent thoughts of death or suicide

Recent drop in school grades or school work

Big decrease in social interaction

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Is tearful, cries often, or is overly sensitive

Category F

Has strange ideas or beliefs that are not real

Has auditory hallucinations in which the child says they hear voices talking to them

Laughs or cries at inappropriate times or shows no emotion in situations

Does extremely odd things such as abnormal preoccupation with fantasy friends or objects

Category G

Is unaware or takes no interest in others or their feelings

Does not seem to need or want comfort when hurt

Cannot imitate others' actions

Does not play with other children

Not interested in making friends

Has difficulty relating to other children

Talks in a strange way, such as a question like a melody or in a monotonous tone

Has difficulty in making socially appropriate conversation

Makes strange body movements like flapping arms

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Has strange interests in or fondness for peculiar objects

Gets very upset over small changes in routine or surroundings

Insists on doing things the same exact way each time

Shows interest in very few things; gets preoccupied with one topic

Category H

Significant delay in language development

Had difficulty learning motor skills like walking, riding a bicycle, drawing, using scissors

Has difficulty in reading, math or writing

Category I- Periods (lasting 2 days or more) where child or adolescent:

Is abnormally cheerful or irritable most of the time

Talks excessively as though they must keep talking

Needs only a few hours of sleep at night

Switches rapidly from one topic, project or activity to another

Is extremely active(goes non-stop)

Does reckless or silly things (dare devil behaviors)

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Is explosive (has lengthy and destructive rages)

Believes that they have special abilities or can do things that are unrealistic

Category J

Tries to avoid contact with strangers; is abnormally shy

Is excessively shy with peers , but generally warm and outgoing with family members and familiar adults

Category K

Worries that parents will be hurt or leave home and not come back

Worries that some disaster (such as kidnapping) will separate them from their parents

Tries to avoid going to school in order to stay home with parent

Refuses to go to sleep unless near parent

Clings to and follows parents around

Complains about headaches, stomachaches, or other sicknesses when they expect to be seperated from parents

Has repetitive behaviors or mental acts (compulsions)

Has panic attacks

Has marked and persistent fear of a specific object or situation

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Category L

Wets bed at night

Wets or soils underwear during daytime hours

Please comment on competence in these areas:

Current school performance

Sports

Recreation

Chores

Social skills with peers and siblings

Additonal Information or Follow up: