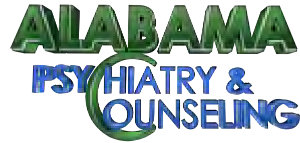


PATIENT REGISTRATION AND INSURANCE

Patient Information

First Name	Last Name	MI	Date of Birth
Address			
City	State	Zip	
Home Phone	Mobile Phone	Work Phone	
Email Address			
Social Security Number	Driver's License Number		
Employer	Occupation		

Primary Insurance / Guarantor Information

Primary Insurance Plan:	Contract Number	Group Number
Name of Policy Holder		Date of Birth
Social Security Number (Policy Holder)	Driver's License Number (Policy Holder)	
Address		
City	State	Zip
Email		
Home Phone	Mobile Phone	Work Phone
Occupation	Employer	

Secondary Insurance / Guarantor Information

Primary Insurance Plan:	Contract Number	Group Number
Name of Policy Holder		Date of Birth
Social Security Number (Policy Holder)	Driver's License Number (Policy Holder)	
Address		
City	State	Zip
Email		
Home Phone	Mobile Phone	Work Phone
Occupation	Employer	

Primary Care Provider / Pharmacy

PCP Name	Phone Number	
Pharmacy Name	Phone Number	
Pharmacy Address		
Pharmacy City	State	Zip

Emergency Contact(s)

Name	Relationship
Home Phone	Mobile Phone
Work Phone	Email

PAYMENT POLICY

- I, the undersigned, hereby agree to pay all amounts and charges for services rendered by Alabama Psychiatry and Counseling no later than thirty (30) days of the rendering of said services unless other specific written arrangements are made. In the event of default in the payment of said services, I waive, as to the debt, all rights of exemptions and laws of Alabama, or of any other state, as to personal property, and agree to pay all costs of collection or securing or attempting to collect or secure said indebtedness, including all reasonable attorney's fees. I understand that I or my responsible party is responsible for my bill, not my insurance company. If my insurance does not pay in a timely fashion, I will pay the bill in full.
- I will be billed a $5.00 service charge for not making a payment at the time of service.
- I understand that I will be receiving automated appointment reminders at any phone number I submit to Alabama Psychiatry and Counseling.
- I also understand that unless a cancellation of appointment is made twenty-four (24) hours in advance of said appointment, that I will be subject to a charge for the time reserved.
- I authorize the release of any medical information to my insurance company that is necessary to process my claims and request payment to Alabama Psychiatry and Counseling.
- I authorize the release of any medical information to my pharmacy or insurance company that is necessary for filling or refilling me prescriptions.

Please indicate your agreement to the terms of this policy by signing below: Date: ___ / ___ / ___

Printed Patient Name: ____

Signature Of Patient: ____

Printed Name of Responsible Party (if not patient): ______________________________

Signature of Responsible Party: ______________________________________

PAYMENT AUTHORIZATION

Alabama Psychiatry & Counseling will directly bill your insurance company following your service. Your co-payment and any 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. Alabama Psychiatry and Counseling accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. WE ASK THAT EACH CLIENT LIST INFORMATION FOR ONE CREDIT CARD TO BE KEPT, CONFIDENTIALLY, ON FILE. The card will automatically be charged in the event of a late cancellation (less than 24-hours notice, a no-show / missed appointment, or other balance that may incur in accordance with out practice policies signed by each patient. The credit card will be used for all clinicians who operate with or for Alabama Psychiatry & Counseling. the card will need to be updated when it expires or information changes.

Cardholder Information:

Name on Card: ______________________________ Phone Number: (_______) ________- ________

Card Type (Check): ❑ **Debit** ❑ **Credit** **//** ❑ **Visa** ❑ **MasterCard** ❑ **American Express** ❑ **Other**

Card Number: ________________________ Expiration Date: ___/___/___ CVV:______ Billing Zip: __________

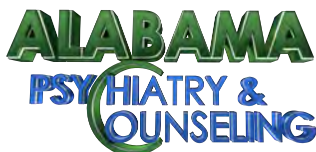
Please indicate your agreement to the terms of this policy by signing below: Date: ___/___/___

Printed Patient Name: ____

Signature Of Patient: ____

Printed Name of Responsible Party (if not patient): ______________________________

Signature of Responsible Party: ______________________________________



PRACTICE POLICIES

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 the appointment. A 24 (twenty-four} hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Appointments for which you arrive late will still end at the appointed time. We do not overbook or double book, so the session is your responsibility for managing. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling *(if applicable)* of the appointment.

Initials ____________

Payment for Services

Alabama Psychiatry and Counseling will directly bill your insurance company following your service. Your co-payment and any 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. Alabama Psychiatry and Counseling accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability.

Initials ____________

Confidentiality

The clinic operates in a "multi-disciplinary" way, meaning that the clinicians function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicide or homicide issues or child/elder abuse or neglect. You will complete a Release of Information that you can list person(s} to whom we may have communications with about you, your care and/or financial matters concerning your account here at Alabama Psychiatry and Counseling. Children (under the age of 17} have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians. Due to the charting nature of Alabama Psychiatry and Counseling and the clinical focus of our work with families (not legal}, custody issues will not be addressed. Additionally, no court ordered evaluations will be performed.

Initials ___________

Treatment Issues

Our office staff will take messages during regular business hours. Please allow 48-72 (business} hours for a response as clinicians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We are able to address routine concerns much more effectively than crisis concerns. If your concern involves a safety issue, please notify the front desk so that your clinician can be paged. If you have an after-hours concern, you may leave a message on our voicemail. If your need is emergent due to safety issues after-hours please call 911 or go to the nearest Emergency Department.

Initials _____________

Laboratory Policy

It may be medically necessary for your physician to request lab or radiologic tests in order to provide the best treatment possible. It is your responsibility, as our patient, to obtain the requested examinations. Our office will assist you as much as possible, but testing may require you to visit another facility or lab. If you do not obtain these tests within a reasonable time, your physician reserves the right to refuse to refill or prescribe further medications until tests are completed. Urine drug screens are performed on patients when necessary. All new patients and patients who are prescribed controlled medication will have an initial urine drug screen 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" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your physician/therapist. You have to find a physician/therapist in another practice. Common Reasons for Dismissal: Failure to keep appointments, frequent no-shows; Noncompliance, which means you have failed to follow physician instructions about an important health issue; Abusive (verbal or physical) to staff; Failure to pay your bill. We will send a letter to your last known 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 options. We will forward a copy of your medical record to your new physician when a release is received.

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

Please indicate your agreement to the terms of this policy by signing below:

Date: _____ / _____ / ______

Printed Patient Name: ____

Signature Of Patient:_____________________________

Printed Name of Responsible Party (if not patient}: _______________________________

Signature of Responsible Party: ____________________

NO-SHOW / MISSED APPOINTMENTS AND LATE CANCELLATION POLICY

It is your responsibility as our 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. **If you miss or fail to cancel an appointment, you will be charged an initial fee of $50.00. Subsequent failures will result in full fee schedule charges ranging from $50.00-$100.00.**

Habitual offenders, more than three missed appointments (late cancellation or no-shows) will be subject to discharge from the clinic.

Insurance will not be billed for these charges and are the patients sole responsibility. Date: _____ / _____ / ______

Please indicate your agreement to the terms of this policy by signing below:

Printed Patient Name: ____

Signature Of Patient: ____

Printed Name of Responsible Party (if not patient): ______________________________

Signature of Responsible Party: ______________________________________

MEDICATION REFILL POLICY

During the course of treatment at Alabama Psychiatry & Counseling, 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. Failure to show or frequently canceling your appointments whereby your medications would be refilled, without rescheduling, is not being compliant with clinic policies and you could be subject to discharge from the clinic. *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 and not request medication refills when you have failed to follow- up appropriately.

Controlled Substances *(including stimulant medications such as Concerto, Addera, etc.)* will be issued by your clinician on a **month to-month** basis. Because these medications are highly regulated, prescriptions must be picked up and appointments must be kept. Also, in the event that a prescription for a controlled substance, or the medication itself, is lost it will not be re-written. Patients are subject to random urine drug screening and pill/capsule or film counts while being prescribed a controlled medication.

Please indicate your agreement to the terms of this policy by signing below: Date: _____ / _____ / ______

Printed Patient Name: ____

Signature Of Patient: ____

Printed Name of Responsible Party (if not patient): ______________________________

Signature of Responsible Party: ______________________________________

CONTROLLED SUBSTANCE(S) CONTRACT

Controlled substance medications *(i.e. benzodiazepines, opioids, amphetamines)* are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal government(s). As a patient of Alabama Psychiatry & Counseling, you agree and understand the following ***(initial each section):***

1) I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if "I run out early," I understand this medication will not be replaced regardless of the circumstances.
Initials ___________

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, weekends or on holidays.
B: Will not be made if "I lost my prescriptions," "ran out early," or "misplaced my medication." I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.
Initials ___________

3) I agree to comply with urine drug testing and pill counts at every appointment, thereby, documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.
Initials ___________

4) 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-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.
Initials ___________

5) I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from Alabama Psychiatry & Counseling.
Initials ___________

6) I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in the office.
Initials ___________

7) I agree to not sell, share, or give any of medication 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.
Initials ___________

8) I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating physician.
Initials ___________

9) I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting mydoctor.
Initials ___________

10) I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine and other addictive substances.
Initials ___________

11) I agree to fill all of my controlled medications at an in-state {Alabama) 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 Alabama Psychiatry & Counseling and complete this information again:
Initials ___________

Pharmacy Name: ________________________________ **Pharmacy Phone No.:** (______) _________________

12) I understand that Alabama Psychiatry & Counseling utilizes the States of Alabama Prescription Drug Monitoring Database and will monitor my prescription history via this source.
Initials ___________

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of Alabama Psychiatry & Counseling in regards to the controlled substances my physician is prescribing.

Patient Signature : ____ **Date:** ___/___/___

MEDICAL INFORMATION RELEASE FORM AND NOTICE OF HIPPA

Patient Name: ____ Date of Birth: ____/____/_____

Release of Information:

__________(Initials) Information is NOT to be released to anyone.

OR

__________(Initials) I authorize the release of information including the diagnosis, records, examinations rendered to me and claims (financial) information.

Information may be released to:

_______Spouse Name of Spouse: ____

_______Child(ren) Name(s) of child(ren): ____

_______Other Name(s): ____

Coordination of Care:

Please list the names and phone numbers of other physicians from whom you are receiving care from.

Name: ____ Phone Number: (____)-______-_________

Name: ____ Phone Number: (____)-______-_________

Name: ____ Phone Number: (____)-______-_________

Alabama Psychiatry and Counseling strives to provide accurate care and therefore requests permission to speak with any other physician(s) who may also be treating you. Please indicate, by signing below, that Alabama Psychiatry and Counseling has your permission to speak with the above referenced physicians to coordinate your care.

HIPPA:

I have received notice of Alabama Psychiatry and Counseling HIPPA Privacy Practices and understand the document completely.

By signing below, I have read the above information and agree to all the contents, including “Coordination of Care” with my physicians.

Date: _____/______/______

Printed Patient Name: ____

Signature of Patient: ____

Printed Name of Responsible Party (if not patient): _______________________________________

Signature of Responsible Party: ____

2015 Stonegate Trail, Suite 105, Vestavia, AL 35243 Phone: (205)440-6292 Fax: (205)313-3177