Alliance Behavioral Health, LLC New Patient Forms

Welcome to Alliance Behavioral Health, LLC. We are delighted that you have chosen us to provide you with behavioral health services. To start, we ask that you complete the following forms in order for us to begin serving you. Please feel free to ask any Alliance Behavioral Health personnel to assist you if you have any questions or concerns. Please submit the completed forms to the administrative staff in office, by fax at 1-256-517-8355, or emailed to our secure account at alliancehsv@hipaamail.net.

Thank you!

Patient Information

Patient Demographics:

First Name: _____Middle Initial: _____Last Name: _____

Preferred Name: _____

Parent/Legal Guardian(s) Contact (if patient is a minor): _____

Address: _____ City: _____ State: _____ Zip Code: _____

Birthdate: _____ Social Security Number: _____

Marital Status: _____ Sex as noted by insurance: ☐ Female ☐ Male

Phone Number: _____ Secondary Phone Number: _____ Email: _____

Emergency Contact: _____ Emergency Contact Number: _____

Who referred you to our office? _____

Who is the Primary Care Physician for the patient being seen? _____

Insurance Information:

Primary Insurance:
Name of Insured (subscriber): _____

Insured DOB: _____

Relationship to Patient: _____

Policy Number: _____

Group Number: _____

Insured's Employer: _____

Secondary Insurance:
Name of Insured (Subscriber): _____

Insured DOB: _____

Relationship to Patient: _____

Policy Number: _____

Group Number: _____

Insured's Employer: _____

Policies Regarding Payment for Services Rendered

Alliance Behavioral Health, LLC or its designated contracted billing company will bill your primary and secondary insurance for services covered under your plan. The patient or the patient's responsible party is responsible for payment of all services that are not paid by insurance. The name and contact information for the contracted billing company is available and gladly provided upon request.

Please be sure to contact your insurance provider to ensure that you are covered for services. Keep in mind that policies for behavioral health services are often separate from your coverage for regular medical services and may have a different policy.

Changes in your insurance information should be communicated with the staff at Alliance Behavioral Health, LLC as soon as you are aware of these changes. Services provided at a time when a policy is inactive or incorrect may not be covered and payment for these services will be the responsibility of the patient or patient's responsible party. Copays, cost sharing, and deductibles are the most common patient responsibilities.

Deductibles: Most Insurance plans have deductibles. These must be met prior to insurance companies picking up coverage. These payments are the responsibility of the patient or patient's responsible party.

Cost Sharing: Some insurance plans cover only a percentage or a set amount of services. The patient or patient's responsible party is responsible for the remainder.

Copays: Most insurance plans require copays. These are often for office visits but may also be designated differently for assessment procedures (i.e. psychological and neuropsychological testing). Patients or the patient's responsible party are required to pay these at the time of each visit without exception.

"Non-Covered" Services: Sometimes certain procedures (assessment or treatment) are not covered by your insurance. These are designated as "non-covered" services. If this is known, you will be notified in advance of any provision of these services. This does not guarantee that your insurance company will cover charges not designated as "non-covered" and communication between you and your insurance company should be maintained to have a better understanding of what is and is not covered.

Court and Legal Related Services: Work involving court appearances and work related to court appearances are "non-covered" services and not billable to your insurance. If your provider is requested to appear or subpoenaed to appear in court, the patient or patient's responsible party is responsible for payment of these services. Services including, but not limited to, court appearances, preparation work prior to court appearances, time spent communication with attorneys, travel, and time reserved in his or her schedule if he or she is on-call are charges to the patient or patient's responsible party. In these cases, a separate written agreement will be formed between the patient or patient's responsible party and the provider.

Non-Treatment and Non-Assessment Services: These include paperwork, professional communications, completion of forms, or attendance and travel for meetings with agencies (i.e. government agencies, school system, etc.). These are "non-covered" services and cannot be billed to your insurance. Fees for services are available upon request or will be provided to you prior to services being rendered.

Providers at Alliance Behavioral Health, LLC make decisions regarding diagnoses, assessment needs, and treatment needs based on clinical information and referral questions. Decisions are not based on your insurance coverage. Some, diagnoses, assessment procedures, and treatments may not be included in your insurance plan. These restrictions vary with different plans and restrictions are considered "non-covered" services. It is recommended that you contact your insurance provider about limitations on diagnoses, assessment procedures and proposed treatments. Providers at Alliance Behavioral Health, LLC will not alter any diagnoses based on insurance coverage beyond simple clarification or greater specification that is supported by clinical information. Providers will discuss assessment and treatment options with you in all cases. "non-covered" services will be the responsibility of the patient or patient's responsible party.

Payments and Costs of Collection: Alliance Behavioral Health, LLC accepts cash, credit cards, and checks. Note that there is an additional $25.00 service charge for returned checks. If Alliance Behavioral Health, LLC is not paid you are responsible for all costs of collection, court costs and reasonable attorney fees associated with collection.

IMPORTANT NOTICE

Late Cancellations and No Shows: Appointments are times reserved for you with your provider. Your time and the time of your provider are valuable. Cancellation of appointments on short notice or not showing for an appointment leaves open time that could be used to provide care to another patient in need. **Late Cancellations** are designated as a cancellation of an appointment with notice given less than 24-hours before the scheduled appointment. **No Show** indicates that a person did not arrive and attend their scheduled appointment without notice of cancellation. This time is not billable to your insurance company and is the responsibility of the patient or patient's responsible party. Cancellations should be made as soon as possible in order to open appointments for other patients in need of services. The Late Cancellation fee is set at $45.00 and the No Show Fee is set at $80.00.
THERE ARE NO EXCEPTIONS.

Insurance Filing: I authorize Alliance Behavioral Health, LLC and its designated billing agency to file claims with my insurance company and provide the insurance company with any requested information needed to assist in processing claims. I also authorize payments be made directly to your provider.

I, _____ (patient name or patient's responsible party) have read this section in its entirety and understand it fully.

_____ Signature of Patient or Patient's Responsible Party

_____ Witness

Date: _____

Date: _____

Specific Alliance Behavioral Health Policies

Cancellation Policy

Patients or patient's responsible party will contact Alliance Behavioral Health, LLC by phone or email no later than 24 hours prior to the scheduled appointment. Fees may be incurred for late cancellations and no shows.

_____ Initial here.

Limitations of Confidentiality

Communication between behavioral health professionals (Clinical Psychologists, Psychiatrists, Psychiatric Nurse Practitioners, and Counselors) are maintained with confidentiality. However, there are limits to confidentiality. These include the following:

1. If the provider believes that the patient is a threat to their own safety or the safety of others.
2. When the records are ordered to be released to a Judge.
3. Information regarding child abuse and neglect, abuse or neglect of a disabled person, or abuse or neglect of the elderly. All providers are mandatory reporters of suspected abuse and neglect.
4. Communication regarding highly transmittable or contagious diseases that pose a public health risk.
5. When patient accounts are turned over to collection agencies or attorneys for non-payment.
6. Cases where you allow others to view your personal records, or misplace personal records, that are in your possession.

_____ Initial here.

Patient Dismissal

At Alliance Behavioral Health, LLC, we feel strongly about providing our patients with the best possible care. Situations may arise that preclude us from continuing care. In some situations, patients may be dismissed from Alliance Behavioral Health, LLC for the following reasons:

1. Not attending scheduled appointments or adequately participating in recommended care.
2. The provider and staff feel that you are a threat to our providers, staff or others visiting or being served in our office.
3. You have been convicted of a sex crime, due to the presence of children and other vulnerable individuals seen in this office.
4. You make sexual advances or attempt to engage in a relationship beyond the therapeutic provider/patient relationship.
5. Other reasons deemed in the best interest of the patient, other patients served, and/or providers.

_____ Initial here.

I have read and initialed all of the above and agree to these policies.

_____ _____

Signature of Patient or Patient's Responsible Party Witness

Date: _____ Date: _____

Notices of Privacy Practices

Alliance Behavioral Health, LLC and its staff and providers produce, review and maintain Protected Health Information (PHI) about patients in this practice. This may be you or a person in your legal custody or care. This information may include personal information, diagnoses, medical history, substance use history, results of tests, treatment records, and treatment plans. This information may be shared with others who are also providing treatment to you or to third parties responsible for payment of services (i.e. insurance companies). This information may also be released to government agencies, a court of law or for managing public safety if mandated. You may with for us to send this information to others and this will require a written consent signed and dated by the patient or person legally responsible for the patient.

In the future, this policy may change. If and when it does, you will be provided access to the updated version.

You have the right to ask s to restrict the disclosure of information about you. You will need to provide this to us in writing. If this occurs, we will need to discuss with you any issues that may arise from withholding this information so that you are making an informed decision. In some cases, the law may not allow for us to retain this information. We will try to respect these wishes if possible and to the degree we are allowed within the law.

You are provided with a written Notice of Privacy Practices for Alliance Behavioral Health, LLC. I, _____ (patient name or patient's responsible party) acknowledge that I have received a copy of the notice of privacy Practices for Alliance Behavioral Health, LLC. I also understand how my Protected Health Information (PHI) will be maintained, ways that it may be distributed, and restrictions and limitations.

_____ _____

Signature of Patient or Patient's Responsible Party Witness

Date: _____ Date: _____

Consent for Behavioral Health Services

I hereby consent to behavioral health assessment and treatment of _____ (patient name), by the providers at Alliance Behavioral Health, LLC. My Signature confirms my understanding that this treatment may include assessment, counseling, psychotherapy, and other forms of behavioral health intervention conducted in accordance with commonly accepted practices and standards in the field of behavioral health.

The outcome of treatment may depend on many variables beyond the control of the treating provider. Therefore, I understand that neither Alliance Behavioral Health, LLC nor a treating provider, can guarantee any specific outcome that will result in my treatment or that or any minor family member. I also understand that any payment for these services, whether made by me or by a third party, is payment made for the Alliance Behavioral Health, LLC provider's Time, experience and effort, and not for any specific outcome.

_____ _____

Signature of Patient or Patient's Responsible Party Witness

Date: _____ Date: _____

Authorization for Contact

Alliance Behavioral Health, LLC wishes to contact patients or patient's responsible party prior to appointments as a courtesy reminder. This office may also need to contact you if there is a change in scheduling, billing need or other urgent matter. Please indicate the methods Alliance Behavioral Health, LLC may contact you:

May we call your home phone number?	Yes_____	No_____
May we call your cell phone number?	Yes_____	No_____
May we call your work phone number?	Yes_____	No_____

Please be aware that emails may not be a secure way to transmit your health information. We will not send Protected Health Information (PHI) through a non-secure email. If PHI must be transmitted through email, we will us our HIPAA secure email to do so, alliancehsv@hipaamail.net. We ask that you use the Patient Portal to access this information. We may wish to contact you by email for appointment reminders and general questions.

May we contact you by your designated email?	Yes_____	No_____

Please be aware that written communication from Alliance Behavioral Health, LLC will contain our business name and contact information on the letterhead and envelope. Patients are encouraged to use the patient portal for billing purposes; however, written statements will be sent by mail.

In the case of a minor, list all individuals that have custody of the minor: _____
If a minor is not in the custody of his or her biological parents, we require that a signed and dated court document be provided to this office before we can see the minor for services.

In the case of a legally dependent adult, list all individuals with power of attorney: _____
We require that a signed and dated court document showing power of attorney be provided to this office before we can see the legally dependent adult for services.

If you wish for us to communicate with individuals or organizations other than yourself, please request separate release forms from an Alliance Behavioral Health, LLC administrative staff member. This may include family members or other health care providers.

Limitations on communications: please indicate any person or circumstances that you do not wish for us to communicate:

_____

_____ _____
Signature of Patient or Patient's Responsible Party Witness

Date: _____ Date: _____