CENTRAL BEHAVIORAL HEALTHCARE, INC.
PATIENT INFORMATION REGISTRATION

_____

Last Name **First** **Middle Initial**

_____

Address- Street **City** **State** **Zip Code**

(____) _____-_____ (____) _____-_____ (____)-____-_____

Home Phone # **Work Phone #** **Cell Phone #**

____/____/____ _____ _____ _____- _____- _____

Date of Birth **Gender** **Marital Status** **Social Security Number**

If Patient is a Minor, Who is Legally Responsible for Charges Incurred

_____

Last Name **First** **Middle**

_____

Address **Street** **City** **State** **Zip Code**

(___)-_____-_____ (____)-_____-_____ _____

Home Phone **Cell Phone** **Relationship to minor child**

_____

Is this person aware they may be receiving a bill for services rendered

EMPLOYMENT INFORMATION

The following is about (check one): Patient _____ Parent _____ Other ____

_____

Employer Name/Company Name

_____

Address **Street** **City** **State** **Zip Code**

(____)-_____-_____ _____

Phone **Employee Name**

How do you plan to pay for services you receive?

____ Self Pay
____ Health Insurance
____ Other: _____

PRIMARY INSURANCE INFORMATION

Insurance Company **Phone Number**

Address No. and Street **City** **State** **Zip**

Identification Number **Group Number** **Employer Name**

Insured Employee Name

Address **Street** **City** **State** **Zip**

____/____/____ _____-_____-_____ _____
Date of Birth **Social Security Number** **Gender**

(____)_____-_____ (_____)_____-_____
Home Phone Employee **Cell Phone Employee**

Relationship to patient: **Self _____ Parent _____ Spouse _____ Other _____**

SECONDARY INSURANCE INFORMATION

Insurance Company **Phone Number**

Address No. and Street **City** **State** **Zip**

Identification Number **Group Number** **Employer Name**

Insured Employee Name

Address **Street** **City** **State** **Zip**

____/____/____ _____-_____-_____ _____
Date of Birth **Social Security Number** **Gender**

(____)_____-_____ (_____)_____-_____
Home Phone Employee **Cell Phone Employee**

Relationship to patient: **Self _____ Parent _____ Spouse _____ Other _____**

I hereby authorize Central Behavioral Healthcare, Inc. to furnish complete information regarding services rendered and to bill my insurance company for all services.
I authorize payment of benefits directly to Central Behavioral Healthcare, Inc. I understand, however, that payments for these services are my own responsibility, If private pay, my signature below represents my responsibility to fulfill this obligation. Billing of your insurance company is a courtesy to you. You are responsible for knowing your insurance benefits and limits. (co-payment, number of visits).

Signature Date

CENTRAL BEHAVIORAL HEALTHCARE, INC.

CONFIDENTIAL HANDLING INSTRUCTIONS

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER
(**CHECK ALL THAT APPLY**)

Oral Communications:

Home Telephone

□ Ok to leave message with detailed information
□ Leave message with call-back number only
□ Other instructions:_____
_____

Work Telephone

□ Ok to leave message with detailed information
□ Leave message with call-back number only

Cell Phone

□ Ok to leave message with detailed information
□ Leave message with call back number

Written Communication:

□ Ok to send mail to my home address
□ Ok to send mail to my work/office address
□ Ok to fax this number: _____

PHI: Personal Health Information:

I permit Central Behavioral Healthcare, Inc to discuss my PHI with and to disclose information to the following:

□ Spouse: _____
□ Adult Child(ren): _____
□ Personal Representative: _____
□ Primary Care Physician: _____
□ Attorney: _____

_____ Date: _____
Signature patient/guardian

_____
Print Name

Acknowledgement of Receipt of "Notice of Psychologist" Policies and Practices to Protect the Privacy of Your Health Information (upon request)

The federal government mandated that as of April 14, 2003 all health care patients are to receive from their clinicians a notice regarding the protection of their private health care information in compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule (45 C.F.R. parts 160 and 164).

This acknowledgement documents that you have received the "Notice" that is required. HIPAA covers what is called "Protected Health Information" (PHI) that is used for treatment, payment, and health care operations. PHI is information in your health record that could identify you.

The notice contains basic information about:

1. How your PHI may be used and disclosed for treatment, payment and health care operations.
2. Which uses and disclosures require authorization from you and which do not?
3. How you may revoke an authorization you may have signed
4. Certain rights you have to restrict use and disclosure of PHI, to receive confidential communications by alternative means and at alternative locations, to inspect and copy your records, to amend your records, to have an accounting of Disclosures.
5. A list of my duties to protect the privacy of your PHI, my right to change the privacy policies and practices described in the Notice.
6. What you can do if you have any complaints about violations of your privacy rights, about decisions about your access to your records I may make.
8. Any restrictions and limitations you or I wish to put on the use and disclosure of your PHI.

The Privacy Notice is a few pages in length. Generally, this Notice is given on a patient's first visit. A copy of the Notice is available upon request.

I acknowledge that I have read the above information and can request a copy of the Privacy Notice (version dated April 1, 2003) as required by the federal government's HIPAA legislation.

Date: _____

_____ _____

Print Patient's Name Signature

_____ _____

Print Parent or Legal Guardian if patient is a minor, or a Personal Representative Signature

Central Behavioral Healthcare, Inc.
Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. (We accept American Express, Discover ,MasterCard ,Visa and Debit)

2. Your insurance policy is basically a contract between you and your insurance company. As a courtesy to you, we will file your insurance claim and the benefits will be paid directly to Central Behavioral Healthcare. If your insurance company does not pay the practice within a reasonable period, (3 months) we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and if you are required to pay a co payment or if you have a deductible to meet, payment is expected at the time of your visit. (unless other arrangements are made)

4. If you are insured by a plan that we are not in network with, we will send the claim for you on an out of network basis. This means the insurer may send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. Not all insurance plans cover all services. In the event your insurance plan determine a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt of a billing statement from our office.

6. **Please be aware that you as a patient are responsible for knowing what type of insurance coverage you have, if the therapist you are seeing is a participating provider, the amount of your co payment or deductible and if a referral is a needed prior to visit. If you have an insurance question regarding your specific plan, please call your insurance company directly.**

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of patient (or responsible party, if minor) Date

_____

Please print the name of the patient