

**PATIENT REGISTRATION FORM**

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Marital Status: Single/Married/Domestic Partnership/Divorced/Widowed/Separated

SS#: \_\_\_\_\_ Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Employer Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

ZIP Code: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Referred By: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Present Medications: \_\_\_\_\_

Have you had previous mental health treatment? YES NO

If yes, WHERE? WHEN? \_\_\_\_\_

**PARENT (for patients under 18yrs old) OR SPOUSE/DOM. PARTNER  
INFORMATION:**

Name:

\_\_\_\_\_

Address:

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code:

\_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone:

\_\_\_\_\_

**INSURANCE INFORMATION**

Primary Insurance Carrier: \_\_\_\_\_ Policy #:

\_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SS#:

\_\_\_\_\_

Group #: \_\_\_\_\_ Patient's Relationship to the Insured: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_ Policy #:

\_\_\_\_\_

Insured's Name: \_\_\_\_\_ Insured's DOB: \_\_\_\_\_ Insured's SS#:

\_\_\_\_\_

Group #: \_\_\_\_\_ Patient's Relationship to the Insured: \_\_\_\_\_

Employer Name: \_\_\_\_\_

**ASSIGNMENT AND RELEASE**

I the undersigned have insurance coverage with \_\_\_\_\_ and assign directly to **Valley Behavioral Services** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for services rendered. I understand that I am financially responsible for all charges whether or not paid for by insurance. I hereby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

**X** \_\_\_\_\_  
Signature of Insured/Guardian

**X** \_\_\_\_\_  
Date

I request that payment of authorized insurance benefits to me or on my behalf to **Valley Behavioral Services** for any services furnished on me by that provider. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for the related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. My signature authorizes releasing of the information to the insurer or agency shown.

**Valley Behavioral Services**  
**708 Will Halsey Way, Ste. C**  
**Madison, AL 35758**

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1. I understand that I must pay my co-pay at the time of visit in full. Personal checks will not be accepted.
  
2. After insurance has paid, I understand that if there is any additional amount due for the visit, I will be responsible for this amount.
  
3. Any outstanding balance that is not paid within 60 days of insurance remittance I understand that I will not be seen by Ammar Alrefai, MD, Keith Watts, PMHNP, Brittney Kendrick, PMHNP, Michelle Pratt, PMHNP or Sarah Miller, PMHNP until the outstanding balance is paid in full.
  
4. If my check is returned, I understand that I will have to pay a \$25.00 fee in addition to any bank charges.
  
5. If I do not give 48-hours notice to cancel my initial appointment, I will be charged a \$40 fee. If I do not give 24-hour notice for any follow-up appointment, I will be charged an \$80 fee. This fee is not covered by insurance and I will be responsible for payment in full before I am able to reschedule my appointment.
  
6. It is my responsibility to notify staff of any changes to my personal or insurance information.
  
7. If paperwork is completed for me in regard to Disability Determination, Leave from work forms, Letters, etc. I will be charged for the doctor's time to complete the forms.

8. Lost or damaged prescriptions and messages left with the afterhour's answering service of non-emergency nature will also incur charges.

9. If I cancel or no show 3 appointments consecutively in a calendar year, I may be dismissed from the practice.

Patient's Signature

Date

#### NATIONAL SECURITY

**Valley Behavioral Services** may disclose medical information to federal officials for intelligence and other national security agencies as required by law.

#### INMATES

If you are an inmate, **Valley Behavioral Services** may disclose medical information about you to the institution or official to which you are assigned.

#### SITUATIONS WHICH REQUIRE AUTHORIZATION

Other uses and disclosures of medical information will be made only with specific, written authorization. You have the right to revoke an authorization at any time except in the instance where entity has already taken action in reliance on this authorization.

#### COMPLAINTS

If you have a question or complaint about the way your protected health information is handled; please contact the privacy officer whose name is listed below.

#### PRIVACY OFFICER

**708 Will Halsey Way Madison, AL 35758 (256) 325-1349.** You may also file complaints with the Secretary of the Federal Dept. of Human Services. You will not be penalized or suffer retaliation if you file a complaint regarding a known or suspected violation of your privacy rights.

#### REVISION OF NOTICE

This notice may be revised or updated from time to time. If the notice is revised or changed, you will be provided a copy of the revised notice. Any revision of the notice will apply to all protected health information that is maintained by **Valley Behavioral Services**. We will also post any revised notice in the front office.

#### EFFECTIVE DATE

This notice is effective on April 16, 2007.

# ACKNOWLEDGEMENT OF RECEIPT

## NOTICE OF PRIVACY PRACTICES

Your signature acknowledges that you have received a copy of the NOTICE OF PRIVACY PRACTICES.

Patient Name \_\_\_\_\_

Signature of Patient \_\_\_\_\_

Date Signed \_\_\_\_\_

Patient Representative (if applicable) \_\_\_\_\_

Relationship of Representative (if applicable) \_\_\_\_\_

# NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review it carefully.

## RIGHTS

Patients of **Valley Behavioral Services** have the right to the following:

- You have the right to request restrictions on certain uses and disclosures of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to any restriction and will advise you if this is the case.
- You have the right to receive confidential communications of your protected health information and may request to receive information from us by alternative means or at alternate locations.
- You have the right to inspect and copy protected health information about yourself. If you desire to review and inspect your medical record, a request to do so may be made in writing to the Privacy officer whose name and telephone number are listed below. You will receive information on the dates available for inspection of your record within 30 days of your request. If you desire to copy any part of all of your medical record, you may also make a request for copies to the Privacy Officer. The copies will

be made and forwarded to you by mail within 30 days of receipt of your request. A charge of \$50.00 plus \$1.00 per page will be assessed to cover the costs of copying and reviewing the material.

- You have the right to request amendments or revisions to your protected health information and to receive a response to your request for an amendment or revision. This means you may request an amendment of protected health information about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us, and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- You have the right to receive an accounting of disclosures of protected health information that were provided without your written authorization. This accounting will be provided one time per year at no cost to you,
- You have the right to obtain a paper copy of this notice if this form is provided electronically.

**Valley Behavioral Services** shall from time to time provide information about you without requesting specific authorization for treatment, payment, and healthcare operations. This is not a complete listing, but is provided as example of how the information may be used:

#### TREATMENT

**Valley Behavioral Services** may confer about your needs and will share pertinent information about you as needed for on call coverage. **Valley Behavioral Services** may share protected health information about you with hospitals or other healthcare providers.

#### PAYMENT

Information about your health will be shared with your insurance company to provide the information they require in order to pay your claim for the services rendered. We may also disclose medical information to your insurance company to obtain prior authorization for treatment and procedures. We may also disclose information about your health or medical billing information to third party billers or outside medical services.

#### HEALTH CARE OPERATIONS

**Valley Behavioral Services** may use health information for operations and activities such as quality control, quality assurance, and financial planning that are necessary to provide efficient and quality care for our patients.

#### APPOINTMENT REMINDERS

**Valley Behavioral Services** staff will contact you by phone to remind you of your scheduled appointments. If you do not wish to have these reminders by phone, please contact the receptionist or the Privacy Officer.

#### SITUATIONS WHICH DO NOT REQUIRE AUTHORIZATION

We are allowed to release medical information about you to the following without an authorization:

#### PUBLIC HEALTH ACTIVITIES

**Valley Behavioral Services** may disclose medical information about you for public health activities such as control of disease, injury, or disability, reporting of child abuse or neglect, reporting of medication adverse events, and in situations related to defective medical products.

#### ORGAN TISSUE DONATION

**Valley Behavioral Services** may disclose medical information to organizations that handle organ transplantation if you are an organ donor.

#### MILITARY AND VETERANS

**Valley Behavioral Services** may release medical information about you to military authorities if you are a member of the armed forces for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Dept. of Veterans Affairs of your eligibility for benefits, or to foreign military authorities if you are a member of that foreign military service. We may disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

#### WORKER'S COMPENSATION

**Valley Behavioral Services** may disclose medical information about you for worker's compensation programs if you have a work related injury.

#### AVERTING SERIOUS THREAT TO HEALTH OR SAFETY

**Valley Behavioral Services** is required to disclose medical information when necessary to prevent a serious threat to your health and safety of others.

#### HEALTH OVERSIGHT

**Valley Behavioral Services** may disclose medical information to a health oversight agency such as audits, investigations, and inspections.

#### LAW ENFORCEMENT

**Valley Behavioral Services** may disclose medical information to law enforcement officials to the extent that the law requires such use or disclosure.

#### CORONERS, MEDICAL EXAMINERS, AND FUNERAL DIRECTORS

**Valley Behavioral Services** may disclose medical information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.

### **REFUND POLICY**

**It is the policy of Valley Behavioral Services that payment is due at the time of service unless other financial arrangements are made in advance. We require all patients to pay their deductible, copay and/or coinsurance payment at the beginning of each visit. At the conclusion of your visit with us you may be billed for any outstanding balances. If there is a credit balance, you will be provided a refund promptly.**

**When your account is reviewed and a refund is approved, we will initiate the refund to your credit card (or original method of payment). You will receive the credit within 7-10 days, depending on your card issuer's policies.**