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

The undersigned has insurance coverage with ______________________________ and assigns 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____

X____

Signature of Insured/Guardian

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 the 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 copay 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 Valley Behavioral Services until the outstanding balance is paid in full, and that my account may be turned over to collections.

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 an $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

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. Valley Behavioral Services may use a secure, HIPAA-compliant AI scribing/dictation tool (Nabla) during appointments to assist providers with clinical documentation. This technology captures spoken information to help generate accurate visit notes, which the provider reviews and approves. Nabla does not make clinical decisions, and patients may decline or withdraw consent at any time without affecting their care.

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 have been made in advance. We require all patients to pay their deductible, co-pay and/or co-insurance payment at the beginning of each visit. At the
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 has been reviewed and a refund has been 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.

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 the 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) ______________________________

Valley Behavioral Services
708 Will Halsey Way Suite C
Madison, Alabama 35758
Phone (256) 325-1349
Fax (256) 325-1354

INFORMED CONSENT FOR TELEMEDICINE SERVICES

Patient Name: **Date of Birth:**

Patient Address: **City:**

State: **Zip:** **Date of Consent:**

Email: **Phone:**

INTRODUCTION:

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and will include measures to safeguard the data and to ensure its integrity against intentional and unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to remain in his/her home or office (or any other remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgement error;

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. ______________________________ (name of provider) has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that it is my duty to inform ____________________ (name of provider) of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my consent for the use of telemedicine in my medical care.

I hereby authorize ______________________________ (name of provider) to use telemedicine in the course of my diagnosis and treatment.

_________________________   _______________

PATIENT'S SIGNATURE   **DATE**
(OR AUTHORIZED REPRESENTATIVE)

____

IF REPRESENTATIVE, RELATIONSHIP TO PATIENT

_________________________   _______________

WITNESS   **DATE**

_________________________   _______________

PROVIDER'S SIGNATURE   **DATE**

I have been offered a copy of this consent form. ________
(Patient Initial)

Valley Behavioral Services

708 Will Halsey Way, Suite C
Madison, Alabama 35758
Phone (256) 325-1349
Fax (256) 325-1354

INFORMED CONSENT FOR THE USE OF SUBOXONE (BUPRENORPHINE)

I, the undersigned, have been duly informed by Valley Behavioral Services of the nature, risks, and possible complications and consequences, as well as available alternative methods of treatment to the Buprenorphine Treatment Program ("Treatment') that he has recommended for me. I understand this Treatment is for the relief of opioid dependence and I hereby voluntarily consent to this Treatment as follows:

1. I agree to adhere to the Treatment as suggested by Valley Behavioral Services, including my regular attendance of scheduled appointments.

2. I understand that the goal of treatment of opiate dependency is to learn to live without abusing drugs. Buprenorphine treatment should likely continue as long as necessary to prevent relapse to opiate abuse/dependence and then be weaned off.

3. It has been explained to me that Buprenorphine itself is a mild opiate drug and can produce some physical dependency.

4. I agree that prescriptions will be provided for me only during my appointment with Valley Behavioral Services. I understand that if I miss an appointment without giving at least 24 hours-notice I may be discharged from Treatment.

5. I agree to take Buprenorphine as prescribed at the dosage determined by Valley Behavioral Services; and not to allow anyone else to take medications prescribed for me. The dose, frequency, and administration of Buprenorphine has been explained to me.

6. I agree not to sell, share, trade, or give my medication to anyone. It is understood that if caught doing so, I will be discharged from Treatment without the chance to be readmitted and that this could be considered unlawful activity by appropriate authorities, and possibly punishable by incarceration.

7. I will safeguard my written prescription and medication from loss, damage or theft. I am aware that a lock box is recommended for those with children. Valley Behavioral Services will not replace lost or stolen prescriptions or medication and he may choose to discharge me from Treatment. Damaged prescriptions may be replaced at Valley Behavioral Services' discretion. I am responsible for the safekeeping of my prescription at all times.

8. I will never alter a prescription in ANY way. I understand this may be a felony, punishable by incarceration.

9. I am aware that if the pharmacy fulfilling my Buprenorphine prescription has any doubts regarding my conduct then they will inform Valley Behavioral Services and inappropriate or suspicious conduct may lead to the immediate termination of my Treatment without any recourse for appeal.

10. I agree not to take any other medications with Buprenorphine without prior permission from Valley Behavioral Services. I understand that overdose deaths have occurred when patients have taken more than the prescribed amount of other medications with Buprenorphine. I agree to share with Valley Behavioral Servicesi a list of any and all of my current medications.

11. I understand that a new prescription of Buprenorphine will not be issued to me in advance of my regularly scheduled appointment.

12. I understand that I may be required at any time with short notice to bring in my medication for Valley Behavioral Services to inspect, count and/or destroy. If I do not show or have the appropriate number of pills, I may be discharged. I may never dispose of Buprenorphine myself without a staff member as a witness.

13. I agree to abstain from all illegal/inappropriate substances including but not limited to: alcohol, marijuana, opiates, cocaine, PCP, ecstasy, LSD, narcotics, amphetamines, or benzodiazepines. I give Valley Behavioral Services the permission to do random drug tests in urine or blood. If my drug screen indicates the presence of illegal/inappropriate substances, or has no buprenorphine or buprenorphine metabolites, I will be discharged.

14. I understand that combining illegal substances, alcohol or other medications with prescribed medication increases my risk of breathing difficulties, heart disorders, and sudden death. If I combine such without express authority from Valley Behavioral Services, I may be discharged from Treatment.

15. I understand the use of Buprenorphine by injection or snorting may cause serious illness or even death. I agree to use Buprenorphine as prescribed and not for any recreational purpose.

16. Not adhering to the above mentioned terms and condition causes termination of my Treatment without any other options.

17. I acknowledge that I have neither asked for nor received any guaranties or promises as to the results which will be obtained. I acknowledge that I will be taking medication at my own risk.

18. I understand that I am required to see a therapist at Valley Behavioral Services monthly prior or adjacent to my monthly medication appointment. I understand that any missed therapy appointments will cause the medication appointment to be canceled and I may be discharged from Treatment.

It is the patient's responsibility to verify and pay all copays IN FULL PRIOR to any appointment.

This form has been explained to me and I acknowledge that I have read and understood its contents.

Patient Signature ______________________________ Date: ________________

Print Name ___________________________