Behavioral Consultant Solutions LLC.

The Solution For All Your Behavioral Needs

NEW PATIENT INTAKE FORM

PLEASE PRINT AND COMPLETE ALL ENTRIES

FIRST NAME	LAST NAME	DATE OF BIRTH
		____/____/____

SEX	SOCIAL SECURITY	PHONE NUMBER	EMAIL ADDRESS
❑ Male ❑ Female			

ADDRESS		
CITY	STATE	ZIP CODE

MARITAL STATUS	SPOUSES NAME	SPOUSE PHONE NUMBER
❑SINGLE ❑MARRIED		
EMERGENCY CONTACT	RELATIONSHIP	PHONE NUMBER

INSURANCE INFORMATION

DO YOU HAVE INSURANCE?	PRIMARY CARD HOLDER	PRIMARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
PRIMARY INSURANCE COMPANY	PRIMARY ID NUMBER	PRIMARY GROUP NUMBER
DO YOU HAVE SECONDARY INSURANCE?	SECONDARY CARD HOLDER	SECONDARY POLICY HOLDER NAME
❑YES ❑NO	❑SELF ❑SPOUSE. ❑PARENT. ❑OTHER_____	
SECONDARY INSURANCE COMPANY	SECONDARY ID NUMBER	SECONDARY GROUP NUMBER

PAYMENT POLICIES

- You are financially responsible for anything insurance does not cover. All copays are due and payable at each visit. The amount your insurance will allow and pay for and your financial responsibility is determined by your insurance company and the policy you have chosen. Your claim will be processed according to the benefits of your insurance plan. The deductible, co-insurance and co-pay are your financial responsibility. It is your responsibility to understand your insurance plan.
- $5 Fee for Co-pays not paid at the time of service.
- $50 No Show Fee for any Missed Appointment that was not cancelled or rescheduled 24 hours prior to the appointment. Please be considerate and call at least 24 hours before your appointment if you cannot come in.
- $35 NSF charge for any returned check from the bank.
- If you are a private patient without insurance, all charges are due at the time of the visit. We do not send a statement to private pay patients.

PRESCRIPTION POLICY

PHARMACY NAME	PHARMACY PHONE NUMBER

- Please do not wait until your last pill to call for a refill. There is a 72 hour turn around for prescription refills. If you have not seen the Physician in six months, the prescription will be Denied.

PATIENT SIGNATURE	DATE

PATIENT MEDICAL HISTORY

Allergies

❑ NONE/Known Allergies	❑ Adhesive Tape	❑ Anesthesia	❑ Aspirin	❑ Codeine
❑ Dairy Products	❑ Iodine/Shellfish/Contrast	❑ Latex	❑ Morphine	❑ Penicillin

OTHER:

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER
Anesthesia Problems		
Arthritis		
Cancer		
Diabetes		
Heart Problems		
Hypertension		
Stroke		
Thyroid Disorder		

SOCIAL HISTORY

□**Yes** □**No** - Do you drink alcohol? □ Daily □Weekly □Infrequently □ Recovering Alcoholic
□**Yes** □**No** - Do you smoke? □ Smoke (___ packs per day) □ Chew
□**Yes** □**No** - Do you drink caffeine? □ Daily □Weekly □Infrequently
□**Yes** □**No** – Are you sexually active?
□**Yes** □**No** – Do you wish to be checked for STDs?

Surgical History: Please list any hospitalizations, surgeries, fractures or major illnesses you have had.

TYPE OF SURGERY	YEAR or DATE	DOCTOR	LOCATION

Medical History: Have you ever had any of the following?

❑ NONE of the problems listed	❑ Chest pain	❑ Hypertension	❑ Osteoporosis
❑ Allergies	❑ Congestive heart failure	❑ Hypogonadism male	❑Pulmonary embolism
❑ Anemia	❑Chronic fatigue syndrome	❑ Hypothyroidism	❑ Seizure disorders
❑ Arthritis conditions	❑ Depression	❑ Infection problems	❑ Shortness of breath
❑ Asthma	❑ Diabetes	❑ Insomnia	❑ Sinus conditions
❑ Arterial fibrillation	❑ Drug/alcohol abuse	❑ Irritable bowel syndrome	❑ Stroke
❑ Bleeding problems	❑ Erectile dysfunction	❑ Kidney problems	❑ Syndrome X
❑ BPH	❑ Fibromyalgia	❑ Menopause	❑ Tremors
❑ CAD coronary artery disease	❑ Gerd	❑ Migraines/headaches	❑ Wheat allergy
❑ Cancer	❑ Heart disease	❑ Neuropathy	
❑ Cardiac arrest	❑ Hyperinsulinemia	❑ Onychomycosis	
❑ Celiac disease	❑ Hyperlipidemia	❑ Organ injury	

Medications: List any medications you are currently taking (please include over the counter medications):

PLEASE PRINT LEGIBLY – NO CURSIVE PLEASE

MEDICATION	DOSAGE	PRESCRIBING DOCTOR

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- • The practice reserves the right to change the privacy policy as allowed by law.
- • The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- • The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- • The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____ (PRINTNAME)

Signature: _____ Date: _____

MEDICAL SERVICES AGREEMENT

Medical Consent: I consent to any treatments or procedures which may be performed on an outpatient basis (including emergency treatment or services), which may include but are not limited to medications, injections, taking of medical photographs, laboratory procedures, and/or x-ray examinations provided to me under the general and special instructions of the physicians, staff, or other health care providers of The Medical Dock assisting my care.

Financial Agreement: I understand that all charges are due at the time of service. I agree to pay The Medical Dock for all charges for healthcare services and professional services provided to me by physicians and other healthcare professionals. Acceptable forms of payment include Cash, Visa, MasterCard, Discover, and American Express. If I am a non-insured patient, I agree to pay for my visit in full at the time of service. If The Medical Dock is a participating provider with my insurance company, I understand that my co-pay, coinsurance, deductible, and/or any outstanding balances are due at the time of service. I understand that my insurance policy is a contract between myself and my insurance company, The Medical Dock is not involved. In order for The Medical Dock to file claims and accept payments from my insurance carrier, I understand that I must present current insurance information at each visit and that The Medical Dock will need to verify my health insurance coverage. In the event that The Medical Dock is not able to verify my insurance eligibility and benefits before my visit, I agree to pay for my visit in full at the time of service. A refund will be issued if my insurance pays for the visit. I also understand that I am financially responsible for any services not covered by my insurance company. When my spouse or a financial guarantor signs this agreement, the spouse or the financial guarantor shall be jointly and individual liable with me. Should my account(s) be referred to an attorney or a collection agency for the collection, the undersigned shall pay the actual attorney's fees (including costs) and collections expenses incurred in addition to the other amounts due. Unpaid accounts referred to outside agencies for collection shall bear interest at the current rate per year from the date of referral.

Insurance Authorization and Release: I request the payment of authorized benefits, including Medicare, and any other government sponsored program, private insurance, and any other health plans to be made to The Medical Dock for any services furnished by that provider. To the extent necessary to coordinate my health care or determine liability for payment and to obtain reimbursement for services rendered, I authorize The Medical Dock to disclose portions of or all of my records, including my medical records to any person or corporation which is or may be liable for all or any portion of The Medical Dock charges, including but not limited to insurance companies, health care service plans, governmental agencies, or worker's compensation carriers. I authorize The Medical Dock to act as my agent to help me obtain any required pre-certification as well as acting as my agent to help me obtain payment from my insurance companies. I authorize my insurance companies to give The Medical Dock any information required to fulfill this function. This will remain in effect until revoked in writing. A photocopy of this assignment and release is to be considered as valid as the original.

Release of Medical Information: I hereby authorize The Medical Dock to release any information in my chart to any practitioner, doctor, hospital, or medical institution to which I may be referred to assist in my care. Additionally, I authorize The Medical Dock to provide a copy of my medical records to my Primary Care Physician (PCP) to allow for continuity of care.

Notice of Privacy Practices: By signing this form, you acknowledge receipt of the "Notice Of Privacy Practices" of The Medical Dock. Our "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. We encourage you to read it in full. Our "Notice of Privacy Practices" is subject to change. If we change our notice, you may obtain a copy of the revised notice by contacting The Medical Dock at (714)596-0400.

In House Pharmacy: I understand that, for my convenience, The Medical Dock can dispense some prescription medications necessary to treat my medical condition(s). I understand that my insurance will not be billed for medications dispensed and that my pharmacy benefits DO NOT apply to this service. **Any medication(s) dispensed in the office are my responsibility and are an additional charge to my office visit charge.** I also understand that if I prefer to use an outside pharmacy, a prescription can be provided to me at no additional charge.

Personal Valuables: The Medical Dock shall not be liable for the loss of or damage to any money, documents, jewelry, glasses, dentures, furs, or other articles of unusual value and shall not be liable for loss or damage to any personal property.
The Medical Dock, A medical corporation and the patient or the patient's representative, hereby enters into this agreement. The undersigned certifies that he/she has read and agree to the foregoing, and is the patient, the patient's representative or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

Signature: _____ Date: _____

Physician Patient Arbitration Agreement

Article 1: **Agreement to Arbitrate**: It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

Article 2: **All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or related to treatment or service provided by the physician including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean the mother and the mother's expected child or children.

All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

Article 3: **Procedures and Applicable Law:** A demand for arbitration must communicate in writing to all parties. Each party shall select an arbitrator (party arbitrator) within thirty days and a third arbitrator (neutral arbitrator) shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party for such party's own benefit. The parties agree that the arbitrators have the immunity of a judicial officer from civil liability when acting in the capacity of arbitrator under this contract. This immunity shall supplement, not supplant, any other applicable statutory or common law.

Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator.

The parties consent to the intervention and joinder in this arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and joinder any existing court action against such additional person or entity shall be stayed pending arbitration.

The parties agree that the provisions of California law applicable to health care providers shall apply to disputes within this arbitration agreement, including, but not limited to, Code of Civil Procedure Section 340.5 and 667.7 and Civil Code Sections 3333.1 and 3333.2. Any party may bring before the arbitrations a motion for summary judgment or summary adjudication in accordance with the Code of Civil Procedure. Discovery shall be conducted pursuant to Code of Civil Procedure section 1283.05, however, depositions may be taken without prior approval of the neutral arbitrator.

Article 4: **General Provisions:** All claims based upon the same incident, transaction or related circumstances shall be arbitrated in once proceeding. A claim shall be waived and forever barred if (1) on the date notice thereof is received, the claim, if asserted in a civil action, would be barred by the applicable California statute of limitations, or (2) the claimant fails to pursue the arbitration claim in accordance with the procedures prescribed herein with reasonable diligence. With respect to any matter not herein expressly provided for, the arbitrators shall be governed by the California Code of Civil Procedure provisions relating to arbitration.

Article 5: **Revocation:** This agreement may be revoked by written notice delivered to the physician within 30 days, or signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

Article 6: **Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is Effective as of the date of first medical services.

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

I understand that I have the right to receive a copy of this arbitration agreement. By my signature below, I acknowledge that I have received a copy.

NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT.

By: _____ Patients Signature

Behavioral Consultant Solutions, LLC

P.O. Box 1139
Richton, MS 39476
Phone: (769) 369-0004
Fax: (601) 788-6719

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

(Also known as Protected Health Information)

PATIENT NAME _____ Date of Birth _____

Address (Mailing) _____ Phone _____

I authorize Behavioral Consultant Solutions, LLC ("BCS"), to use or disclose information from my mental health record which will include my protected health information ("PHI") and which may include information about psychiatric diagnosis and treatment and substance abuse as set forth below. I understand that this authorization is voluntary. I authorized BCS to disclose my mental health record and its PHI to:

Name:_____ Phone _____

Address:_____ FAX _____

Dates of Treatment: _____

Information to be released (Please describe) _____

Purpose of Disclosure _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the Behavioral Consultant Solutions, LLC, at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at Behavioral Consultant Solutions, LLC, will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that in compliance with MS Medical Records charges, personal copies will be assessed at a fee of $20.00 for the first 20 pages, pages 21-100 at $1.00 per page, pages 101+ at $0.50 per page. There could be an off-site $15.00 retrieval fee, $25 certification fee. A ten (10%) percent charge may be applied for postage and handling.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ OR _____ _____

Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____

Relationship to Patient

Behavioral Consultant Solutions, LLC
Telephone: (769) 369-004 Fax: 601-788-6719

Treatment Consent, Authorization of Benefit, Acknowledgment of Privacy Practices

Patient _____ **DOB**_____

Facility_____ **(the Facility")**

Address_____

The above-mentioned Facility has contracted with Behavioral Consultant Solutions, LLC ("BCS") to make medical and/or psychological health services available to you through BCS's providers, clinicians, and counselors (collectively the "Providers"). The services provided by these Providers will be covered under this document.

Consent to Medical, Mental, and/or Behavioral Health Treatment

I, for myself, (or the patient named below) hereby consent to and authorize medical and or psychological health treatment which may include the performance of evaluations, examinations, treatments, offered screening tests, patient questionnaires and/or diagnostic procedures which BCS's Providers have advised me of and determined to be medically necessary.

By consenting, I have been informed and recognize the selection of medical, mental, and/or behavioral health services that will be provided by the Provider(s) associated with BCS, and any related procedures regarding billing. I hereby permit and consent to be evaluated and treated for medical, mental, and/or behavioral health services as ordered by BCS's Provider(s) and/or requested by my responsible obligator. (ex. Through a power of attorney, self, guardian, supported decision maker). I understand and agree that all or a portion of the services from the Provider(s) may be provided by telehealth via audio and visual means. The Facility will explain the process for connection to and provision of telehealth services.

Confidentiality

Under most circumstances, the communications between a Provider and a patient is held confidential, except in the following situations;

1. In the event someone becomes a danger to themselves and others;
2. A valid court subpoena;
3. Existing suspected abuse (physical, mental, financial, or sexual); or
4. As otherwise required by law.

Release of Information

I hereby authorize BCS to release any medical information deemed necessary to process insurance claims (including personal health information relating to the treatment of drug abuse, alcohol abuse, and/or mental illness).

Authorization of Payment:

I further authorize payment of any health insurance benefits directly to BCS for services provided to me or my dependent by BCS or BCS's Providers. This authorization applies to any insurance benefit that was in effect at the time the services were provided. I request that payment under the Medicare insurance program, Medicaid, and/or private insurance plans to be made by the supplier or group on any costs and/or fees associated with services provided by BCS or BCS's Providers. I permit the holder of medical or other information about me to release the same to the Centers for Medicare and Medicaid Services and its agents and any information needed to determine and process these benefits and for related services. I request that payment of authorized Medicare, Medicaid program, and/or private insurance plan benefits be made on my behalf to BCS and/or its Provider(s). I permit any holder of medical information about me to release any information needed to determine these benefits or the benefits payable for associated services. I hereby agree to pay in full any balance on my account in accordance with the BCS Payment and Credit policies, which may include reasonable attorney's fees. A copy of BCS's Payment and Credit policies have been given to me. The balance due will, at a minimum, include provisions set by my insurance company such as copayments, deductibles, and "usual and customary" allowances. BCS reserves the right to change fees and policies without notice.

Notice of Privacy Practices

I recognize that I have certain rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA). I understand that this information can and may be used to:

1. Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment either directly or indirectly.
2. Conduct normal healthcare operations, such as quality assessments and physician certifications.
3. Obtain payment from third-party payers.

I acknowledge that BCS has provided me with a copy of its Notice of Privacy Practices. I understand the Notice describes BCS's privacy practices regarding the use and/or disclosure of patient health information.

Effective Dates of Agreement

I understand that the Privacy Notice may be changed from time to time, and that I may request a copy of the Privacy Notice's practices at any time, by calling or faxing the numbers above, or in writing to the BCS. I understand this authorization remains in effect unless authorization is revoked by me or an updated notice is required by the Facility and/or BCS. I understand that I may determine how my private information is used or disclosed to carry out my treatment, and have payments made on my behalf. I understand that the Provider is not obligated to agree to my restrictions, but if BCS and I agree, then BCS is obligated to abide by my restrictions within local, state, and federal regulation

The patient's signature must be witnessed by a Facility staff member. The witness agrees to explain to the signer-patient that this consent is for medical, mental, and/or behavioral services. The witness agrees to explain or read to the signer-patient this consent is also for authorization of assignment of benefits and gives authorization to the signer/patient if the signer/patient is not able to read it himself/herself.

By my signature below, I acknowledge that I have read understand and agree to be bound by the terms of this consent form, including the specific language related to behavioral or mental health services. I have had the opportunity to ask questions, and that any questions have been satisfactorily answered.

□**Patient** gives consent and authorization
□**Patient** gives consent, and authorization, but is unable to sign his/her name for the following reasons:

□Physical or medical limitation □ Unable to read □ Signs with mark i.e., "X

Patient Signature_____ Date_____

Facility Witness_____ Date_____

Patient Email Address_____

Patient Phone Number_____

□**Patient Representative** gives consent and authorization as

□Power of Attorney □Responsible Party □Legal Guardian

_____ Date_____
Signature of Patient, Responsible Party, or Legal Guardian

Patient Representative Email Address_____

Print Name_____Relation_____

Facility Witness_____ Date_____

Telephone Permission by _____Phone_____

1-Facility Witness_____ Date _____

2-Facility Witness_____ Date _____

Provider's Order /Referral

Medical, Mental, and/or Behavioral Health Services

A provider's order is required for any diagnostic evaluations, assessments, or screenings performed by Behavioral Consultant Solutions ("BCS"). A licensed medical and/or mental health provider will/can conduct the following with a provider's consent: Medical consultation and treatment, Psychotherapy services, E/M services, and or any other medical or behavior management processes within the Provider's licensed scope of practice. It is mandatory to mark all applicable fields that indicate the need for a referral to a behavioral health professional in order to initiate any medically appropriate mental/behavioral health services. Please thoroughly describe symptoms and behaviors determined during the care plan, RAI process, nursing notes, and assessments.

Date_____ **Patient Name**_____

Room#_____ **DOB**_____

Facility_____

Address_____
Facility Type □Nursing Facility □Assisted Living □Independent/Home
Is the Patient receiving Hospice benefits? □Yes □No
Is the Patient cognitive and an appropriate candidate for counseling? □Yes □No □Undetermined

Please check the selection(s) that applies for this referral <u>ONLY</u> (Only one box selected in this section)
□Medical Management & Treatment □ Psychiatric Medication Management Service
□ Psychotherapy (Counseling) Service □ **ALL** Medical, Psychiatric, and Counseling Services

Please provide a reason for referral_____

_____

Referring Provider/ Agency (please print) _____

Referring Provider/Agency Signature _____**Date**_____

*<u>Facilities, **please fax** all **SIGNED orders** with **face sheet** to **601-788-6719**. Thank you for all your participation and support. Remember, we are here for all your behavioral needs!</u>*