BRIGHTLAND HEALTH

NEW CLIENT REGISTRATION

INFORMATION

Legal Name:_____ Date of Birth:_____

Sex: □ Male □ Female Marital Status: □ Single □ Married □ Other

If different than above, preferred name and gender: _____

Street Address:_____

City: _____ State_____ Zip:_____

Phone:_____ Email:_____

INSURANCE INFORMATION

Insurance Provider:_____

ID/Policy # _____ Group#_____

Subscriber/Insured's Name _____

Date of Birth_____

(if different than patient)

Address_____

City:_____ State:_____ Zip:_____

PRIMARY CARE

From whom or where do you receive your primary medical care? Clinic/Doctors:

Name:_____

Telephone:_____Address:_____

EMERGENCY CONTACT

Name:_____Relationship:_____

Telephone:_____

Referred by: _____

Please provide a copy of all of these: □ Photo ID □ Credit Card □ Insurance Card

BRIGHTLAND HEALTH

CONSENT TO RELEASE INFORMATION FOR PROCESSING BENEFITS

I hereby authorize Brightland Health to release any of the following requested information for the purpose of obtaining reimbursement for treatment services provided directly to my dependents or me. This information may include: designated clinical records (i.e., diagnosis, treatment plans, progress notes, test results, etc.)

Information may be released to any or all of the following as needed: Any third party payer having responsibility for payment of charges for treatment; review agents/auditors, managed care agents.

This consent is valid until such time that all claims have been settled to the satisfaction of Brightland Health or up to one year from the date of discharge from treatment, whichever is longer.

I understand that in some cases I (and/or my dependents) may be receiving services for which I am not the insured or for which there is more than one insured. In this case, I authorize Brightland Health to contact the actual or additional insured (e.g., my spouse) and to share information necessary to obtain reimbursement for services.

I understand that I may revoke this consent at any time and that I may inspect and copy the information to be disclosed. I further understand that I can invalidate the consent at any time before the expiration date so long as I submit my revocation in writing to this office. In addition, the agency reviewing the clinical information and/or records will be advised not to re-disclose my records to any other agency/person without my written consent.

I understand that I am ultimately responsible for any and all charges not paid for by my medical insurance, and that if I refuse to sign this Release of Information, I will likely have to pay for any and all charges incurred.

I certify that I am the client and that I have received a copy of this form. If I am not the client, I certify that I am duly authorized as the client's general agent to execute the above and accept its terms.

ASSIGNMENT OF BENEFITS: In consideration of services to be provided to me or to my dependent, I hereby assign, transfer, and set over to Brightland Health all of my rights, title, and interest to reimbursement benefits under my insurance policy(s), including all major medical benefits. I understand that I am financially responsible to Brightland Health for charges not covered by this assignment.

_____

Print Patient's Name

_____ _____

Signature of Patient (or Authorized Representative) Date

HIPAA CONSENT FORM

Consent to Use and Disclose your Health Information

I understand that I have certain rights to privacy pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Brightland Health to use and disclose my protected health information to carry out:

-Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment)
-Obtaining payment from third party payers
-The day-to-day healthcare operations of practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

_____

Print Patient's Name

_____ _____

Signature of Patient (or Authorized Representative) Date

PSYCHIATRY AND PSYCHOTHERAPY FEES

I understand that the arrangement for payment is as follows:

Self-Pay Services:

• PSYCHIATRY INTAKE	$350.00/SESSION
• PSYCHIATRY FOLLOW UP SESSION	$250.00/SESSION
• PSYCHOTHERAPY INTAKE (Therapist)	$225.00/SESSION
• PSYCHOTHERAPY FOLLOW UP SESSION (Therapist)	$200.00/SESSION
• LETTER WRITING AND DOCUMENT PREPARATION	$30.00/20 MIN

I understand that these rates may increase periodically and that I will be informed prior to any rate changes. If using insurance for payment, I understand that if my clinician is in my network he/she has agreed to the usual and customary rate deemed appropriate by his/her contract with my insurance company. Furthermore, I understand that my clinician may not charge me for the difference between the fees listed above and the agreed upon usual and customary rate beyond the copay/coinsurance required by my insurance. I understand that my copay is due at the time of service. If using insurance for payment I understand that my insurance company reserves the right to refuse payment for services. In such a case I have the right to appeal to my insurance company for payment. I understand that I am ultimately responsible to pay for services provided that are not covered by insurance.

If not using insurance, I understand that I am responsible for the full charges of each session at the time of service, unless an alternative arrangement is made with the clinician.

I understand that a credit card is required to be held on file. I Authorize Brightland Health to charge my credit/debit card for services not paid by my insurance company within 90 days from services rendered, including copays, deductibles, and/or coinsurance. If any such amounts are not settled within 90 days, the account will be turned over to an independent collection agency.

CANCELLATION POLICY:
Cancellations made with less than 24 hours notice will be charged at a missed appointment fee of $100.00. Insurance does not cover missed appointments.

_____
Print Patient's Name

_____ _____
Signature of Patient (or Authorized Representative) Date

PHONE AND EMAIL POLICY

I understand, in general, some providers are available to speak to patients outside of business hours especially in case of an emergency. Some providers do not provide crisis support. In a psychiatric emergency, it is recommended to call 911 or go to the nearest Emergency Room. All other matters are best discussed in session. I understand that it has been suggested that if I am experiencing distress that I schedule an appointment with my provider as soon as possible.

Any phone call to a mental health provider that lasts 10 minutes or longer may be charged. I can discuss with my provider his or her specific phone-call policy and rates.

I understand that email is a convenient and efficient way to communicate non-urgent matters to my provider. I understand that the confidentiality of emails can not be guaranteed and should not be used in emergencies. Emails may be used for appointment reminders.

By signing this form, I consent to receiving emails and voicemails from my mental health provider, if necessary.

Note: I understand that I may opt out of voicemails or emails. If I decide to do so I understand that I will not receive appointment reminders. I will notify Brightland Health if I decide to limit, in any way, the use of email or phone calls.

_____

Print Patient's Name

_____ _____

Signature of Patient (or Authorized Representative) Date