

Arizona Behavioral Health Specialists, LLC

IDENTIFYING INFORMATION

Patient Name: Last: _____ M.I. _____ First: _____

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Date Of Birth: _____ Sex: _____ SSN: _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widowed _____

Full Time Student: _____ Name of School: _____

Place of Employment: _____ Work Phone: _____

Address: _____

Referred By: _____ Phone: _____

RESPONSIBLE PARTY:

(Guardian accompanying minor child to appointment)

Check if Same as Above: _____

Name: Last: _____ M.I. _____ First: _____

S.S.N. _____ D.O.B. _____ Relation to Client: _____

Address: _____ City/State: _____

Zip Code: _____ Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

INSURANCE INFORMATION:

(Please note the information needed is on the person who has the coverage, usually through employment, which may or may not be the client.) (Please Print)

Insurance company: _____

Name of Insured: _____ Relation to Client: _____

SSN of Insured: _____ D.O.B. of Insured: _____

Insured Employer _____

Check if benefits are under Employee Assistance Program (EAP) _____

(If EAP, continue to next page)

EAP INFORMATION

Please fill out if EAP:

Name of Insurance EAP is through: _____ Phone Number: _____

Place of employment of the Insured: _____ Authorization Number: _____

Arizona Behavioral Health Specialists, LLC
10000 North 31st Avenue C 202
Phoenix, AZ 85051
602-997-6635
FAX: 602-997-6642

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. This notice is effective April 14, 2003.

- I. It is our legal duty to safeguard the privacy of your health information. We are required to provide you with this notice describing our privacy practices and your rights regarding your medical information. We are required to follow the privacy practices described in this notice. We reserve the right to change our privacy practices. Before any important change is made, we will change this notice and make the new notice available.*

- II. We will use and disclose your medical information for the following purposes. We will not disclose your medical information for any other purpose not listed below, without your specific written authorization.*
 - a. Treatment: Your medical information may be disclosed to physicians, psychiatrists, psychologists, and other health care providers who provide you with health care services.*
 - b. Health Care Operations: Your medical information may be disclosed for operation of this practice. Example: Quality Control Evaluations or other administrative, financial, or legal activities necessary for our operation.*
 - c. Payment: To bill and collect payment for the treatment and services you receive.*
 - d. Emergency Situation: Your medical information may be disclosed if you are in need of emergency treatment and your consent cannot be obtained.*
 - e. When Legally Required: Your medical information may be disclosed when required to do so by any Federal, State, or local law.*
 - f. Judicial and Administrative Proceedings: In response to a Court or Administrative Order, Subpoena, or other lawful process.*
 - g. Worker's Compensation: To comply with laws related to Worker's Compensation.*
 - h. Victims of abuse and neglect reporting laws: We may disclose your medical information if it is necessary to prevent a serious threat to your health or safety or the health and safety of others.*
 - i. Notification: For appointment reminders.*
 - j. National Security or Intelligence purposes.*

- III. Your individual rights regarding your medical information.*
 - a. The right to request limits on use and disclosure of your medical information.*

You may request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree with the additional restrictions, but if we do, we will abide by our agreement.

- b. The right to see and get copies of your medical information. If you request copies, you may be charged for each page and postage if you want the copies mailed to you.*
- c. The right to choose how your medical information is sent to you. You may choose an alternate address or alternate means of receiving your medical information.*
- d. The right to amend your medical information. If you believe there is an error in your medical information or that important information has been omitted, it is your right to request corrections be made or additional information added. Your request and the reason for the request must be made in writing. You will receive a response within sixty days of receipt of your request. If your request is denied, you will be provided a written explanation. If your request is approved, the changes will be made.*
- e. The right to get a list of disclosures of your medical information. The list will not include uses or disclosures to which you have already consented (i.e. for payment), non-disclosures made before April 14, 2003.*

IV. Questions and Complaints: If you believe your privacy rights have been violated, or if you object to a decision made about access to your medical information, you are entitled to file a complaint by contacting the ABHS HIPPA Privacy Officer at 602-997-6635. You may also contact the secretary of the Department of Health and Human Services. Anyone who chooses to file a complaint will not be subject to retaliation.

V. Acknowledgement: I have received the Notice of Privacy Practice and I have been provided an opportunity to review it.

Patient name: _____

Patient / Guardian's Signature: _____

Date: _____

Arizona Behavioral Health Specialists, LLC

10000 North 31st Avenue Suite C202 Phoenix, Arizona 85051
Office: 602-997-6635 fax: 602-997-6642 e-mail: abhs@azbehavioral.com

OFFICE PROCEDURES / CONDITIONS OF EVALUATION / TREATMENT

Welcome to Arizona Behavioral Health Specialists, LLC. Please read the following information carefully as it contains important information regarding our office policies and your treatment and / or treatment of your child. This form provides you with information that is in addition to that detailed in the notice of privacy practices.

Appointments: *All services are rendered by appointment only at a mutually agreed time. Scheduled appointments must be canceled 24 hours in advance or you will be responsible for a charge which may be 50% to 100% of the regular appointment fee.*

Financial Agreement: *You are responsible for supplying all current and correct billing and insurance information, including secondary coverage, to our office at the time of your first appointment. We will bill your insurance as a courtesy to you. Please be aware that most insurance companies require you to obtain authorization prior to the start of treatment. You will be responsible for all charges not covered by your insurance, including any denied charges. Any fees, including co-payments and deductibles, are due at the time of service. You will be responsible for any processing fees charged for checks returned by the bank. Please notify our office within ten days of any changes in insurance coverage, address, or telephone numbers. In the event collection / legal efforts are utilized to collect a past due balance, you will be responsible for payment of all fees connected with those efforts. If you require other professional services, such as preparation of reports, letters, telephone consultations, or other correspondence not completed during scheduled appointment times, you will be responsible for any charges. Fees are based on time spent.*

Insurance/Managed Care: *Please be aware that many managed health plans are often oriented towards a short-term treatment approach designed to resolve specific problems that are interfering with one's own usual level of functioning. It may be necessary to seek additional approval after a certain number of sessions. While short-term treatment can be very beneficial, many clients felt that more sessions are necessary after insurance benefits expire. It is important to remember that you may have the right to pay for services yourself and avoid the complexities associated with insurance reimbursement. You also have the right to self bill your insurance company for reimbursement of services (for providers who are not in your insurance network or those not accepting insurance). Your insurance company will supply you with the necessary information needed to self-bill. If needed, our office will supply you with the necessary information needed for self billing (Tax ID # and Diagnosis Code) upon request.*

Confidentiality: *In general, all information shared in treatment is confidential and can only be released with your written permission. However, there are some exceptions. ABHS may disclose all or part of your records to the following third parties for financial reimbursement: insurance companies, workers' compensation, government agencies and other fiduciaries. Information is typically limited to diagnosis codes, treatment plan or treatment summaries, and in rare cases, a copy of the entire record. Your treatment may be discussed with another professional in our practice for the purpose of consultation. In these circumstances every effort is made to avoid revealing your identity. It may be necessary to discuss your treatment with your primary care physician or other treating physician for the purpose of providing continuity of care. There are other rare situations where steps may be required to take protective action when there is a threat of serious bodily harm to self or others. Please be advised that if there is an assessed potential for self harm or harm of others, confidentiality does not exist. These steps may include notifying*

the potential victim, notifying the police or other agency, family members or seeking appropriate hospitalization. There are other situations in which the law requires action to protect others from harm, such as suspected abuse of a child, elderly person, or disabled person. A report must be made with the appropriate State agency and / or the law enforcement agency under those circumstances.

In the instance of the psychotherapy treatment of a child who is the identified patient, the positive psychotherapeutic process involves that we maintain the confidentiality of the child for a positive treatment process. While the parent or guardian provides consent for evaluation and /or treatment, the confidentiality in this instance is maintained with the child. We will provide pertinent clinical information including diagnosis, recommendations, treatment summaries, and / or verbal or written updates. At the time of visits general clinical information / recommendations may be provided. The exception to confidentiality is if there is any risk to the child such as the potential for self harm and / or high risk behaviors. As part of this consent agreement for evaluation / treatment the usual access to treatment records per ARS / Federal (statutes/regulations) is waived by the parent / guardian to have you provided with treatment records. This does not waive your right to have information released to other individuals such as other mental health providers, physicians, and/or education institutions. The therapeutic impact of any request for records will be discussed with you and if you should choose to revoke this waiver, the potential impact on ongoing treatment will be discussed.

Individuals sometimes inquire about mental health professionals providing information related to forensic (legal) actions. Please be advised that you / your child is being evaluated / treated in a clinical setting and that any request for an expert opinion related to litigation will not be provided. That includes issues related to custody, visitation, and / or other court related issues.

Confidentiality of e-mail, cell phones and fax communication: *Please be aware that privacy and confidentiality of these forms of communication can be compromised. Please notify us at the beginning of treatment if you have any concerns regarding the use of these communication devices.*

Your signature below indicates you have read our policies carefully, understand them, and agree to be bound by them during and after treatment at Arizona Behavioral Health Specialists, LLC. Your signature will further authorize Arizona Behavioral Health Specialists to conduct an evaluation and perform treatment for you and / or your dependent child with regard to psychological or behavioral health problems. If you are seeking treatment for your child we may also request that the other parent provide consent for evaluation / treatment.

Client/Parent and / or Guardian Signature

Date

If patient is a minor this form must be signed by biological parent or legal guardian. If you are not the biological parent or legal guardian, please notify our office staff immediately as your appointment may have to be rescheduled. If you have guardianship, please provide us with documentation. We may also ask you to provide a copy of a divorce decree if pertinent.