Southern Behavioral Healthcare, P.C.

110 Braxton Court
Fayetteville, GA 30214
Phone (770) 461-6422; Fax (770) 461-0498

APPLICATION FOR SERVICES

Patient Information
Full Name _____
Street Address _____ Apt _____
City _____ State ___ Zip_____
Home Phone _____
Cell Phone _____ Work _____
SSN _____ DOB _____
Age _____ Sex _____ Marital Status _____

Patient Occupation
Employer/School _____
Grade _____ Length of Employment _____
Address _____
City _____ State _____ Zip_____
Phone _____
Occupation _____

Parent/Legal Guardian
Employer _____
Address _____
City _____ State ___ Zip _____
Phone _____
Occupation _____

Emergency Contacts
Name _____
Relationship to patient _____
Telephone Number _____
Name _____
Relationship to patient _____
Telephone Number _____
Name _____
Relationship to patient _____
Telephone Number _____

Who should we thank for sending you to our office?
Name _____
Telephone _____
Address _____
City _____ State_____ Zip _____

We will file your insurance for you as a service; however, you (patient, parent or legal guardian) are ultimately responsible for the all co-pays, deductibles or co-insurances. It is the patient's responsibility to know the benefits you have with your insurance company. If authorization or prior approval is needed, it should be obtained by the patient, parent or legal guardian. We will make every effort to file with the insurance information you give to us. If for whatever reason the insurance company does not pay for services rendered, the patient, parent or legal guardian will be expected to pay for such services.
I have read and fully understand my responsibilities.

_____ _____
(Patient, Parent or Legal Guardian) Date

Insurance Information

Primary Insurance
Name of Insurance _____
Customer Service Number _____
Phone Number _____
ID Number _____
Group Number _____
Who is the primary person on this insurance?
Name _____
SSN_____ DOB _____
Relationship to patient? _____
Employer _____
Phone _____

Secondary Insurance
Name of Insurance _____
Phone Number _____
ID Number _____
Group Number _____
Who is the primary person on this insurance?
Name _____
SSN_____ DOB_____
Relationship to patient? _____
Employer _____
Phone _____

Tertiary Insurance
Name of Insurance _____
Phone Number _____
ID Number _____
Group Number _____
Who is the primary person on this insurance?
Name _____
SSN_____ DOB _____
Relationship to patient? _____
Employer _____
Phone _____

Authorization for payment
I hereby, authorize payment of medical benefits and the release of information necessary to process claims to my insurance company or the party responsible for payment to Southern Behavioral Healthcare, P.C.

_____ _____
Patient, Parent or Legal Guardian Date
Relationship to patient _____

Who is completing this form?
Name_____
Relationship to patient _____
Phone _____

Southern Behavioral Healthcare, P.C.

Authorization for Use and Disclosure of Protected Health Information HIPAA LAWS

I, _____have received from Southern Behavioral Healthcare, P.C. my copy of the HIPAA Privacy and Disclosure Law for patients. I understand that a copy of this law is also posted in the waiting room for my convenience. At any time I may have any questions answered by the designated person in this office.

I understand that it is my responsibility to make sure that I fully understand these laws and/or ask questions to receive an understanding. This signed copy will be placed in the patient's chart as a part of his/her permanent record. A copy maybe provided to you upon request.

_____

(Patient's or legal guardian signature)

_____

(Witness/Office Personnel)

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AUTHORIZATION FOR TREATMENT

I hereby authorize Southern Behavioral Healthcare, P.C. to utilize any recognized treatment procedure or support services, subject to my understanding and agreement that will assist me in resolving the problems for which I am seeking treatment/assistance. For the purpose of this agreement, services available shall include, but not limited to:

1. Mental health assessment and evaluation
2. Treatment planning and implementation
3. Interventions
4. Referrals for additional services
5. Arrangement of follow-up services when appropriate
6. Discharge planning

Signature of Client: _____Date:_____

Parent/Legal Guardian: _____Date:_____

Witness: _____Date:_____

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Southern Behavioral Healthcare, P.C
Financial Policy

It is the policy of Southern Behavioral Healthcare to require all current insurance information on every patient at the time scheduling the appointment. No appointment will be made without this information. Southern Behavioral Healthcare will verify coverage and confirm that Southern Behavioral Healthcare is the primary care physician of record. The responsible party must inform Southern Behavioral Healthcare of any changes in coverage for existing patients prior to scheduling an appointment. All current patient balances are to be paid prior to scheduling an appointment.

Per contact with insurance payers, Southern Behavioral Healthcare is to collect appropriate co-payments from every patient/parent/responsible party at check in, prior to services being rendered. Responsible party will be required to show proof of current insurance (insurance card) for each patient at each visit.

It is the policy of Southern Behavioral Healthcare to collect the patient portion of coinsurances, deductibles, non covered procedures, and tests at check out based on insurance company allowed amounts. Uninsured patients (self pay) must pay for all services on that day of service at check out.

It is the policy of Southern Behavioral Healthcare to mail as few patient statements as possible, in an effort to reduce healthcare costs. If a patient balance (due from patient) is incurred, responsible parties are encouraged to mail the payment directly to Southern Behavioral Healthcare upon receiving the EOB (explanation of benefits) from their insurance company. It is the policy of Southern Behavioral Healthcare to mail one statement it is necessary for Southern Behavioral Healthcare to mail a second statement because no payment has been received, an interest charge of a flat 12% of the balance, but not less than $5, will be added to the account. If no payment is received 10 business days after the mail date of the second statement, the account will be reviewed and turned over to the collection agency. **All accounts turned over to the collection agency will also be responsible for the collection agency fees.**

No appointments will be made for the responsible party while the account is in collections with the collection agency.

Coordination of benefits: Responsible parties must respond to the request for information from the insurance within 10 business days. A failure to respond to a request for COB information from the insurance will result in all charges becoming patient responsibility.

Returned checks: Any checks returned to Southern Behavioral Healthcare for insufficient funds (NSF) will incur a $25 charge. It is the responsibility of the check signer to pay, by cash or credit card both the check amount and $25 charge immediately. A failure to respond to Southern Behavioral Healthcare within 10 business days will result in the NSF check and charge being turned over to the collection agency. **Check signer will also be responsible for all collection agency fees.**

I, _____ , have received and understand the Southern Behavioral Healthcare financial policies.

Signature of Client: _____Date:_____

SOUTHERN BEHAVIORAL HEALTHCARE, P.C.

REV. FEB 2020

Notice of Privacy Practices- Short Version

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.THE PRIVACY OF YOUR HEALTH INFORMATION IS VERY IMPORTANT TO US.

Our Commitment to Your Privacy:

Our practice is dedicated to maintaining the privacy of your personal information. We are required by law to provide you this important information. If you have any questions or concerns after reading the NPP, please let us know.

The information we acquire from you and others about your health will be used to/for:

1. Provide you with proper treatment
2. Arrange payment for your services
3. Business activities that may be called on by the law or other healthcare agencies

It is necessary for us to have signed acknowledgement from you upon receiving this information and your consent to the understanding and agreement of the terms outlined in the NPP prior to receiving treatment in our office.

Before your information is sent, shared, or released for any other purpose by us or upon your request, we will discuss it with you and obtain a signed authorization from you allowing this to happen. This authorization will then become a permanent part of your medical records.

We will keep your health information private, however, there might be times when the law requires us to share or disclose this information. Examples of this may include:

1. When there is a serious threat to your safety or health, another individual, or the general public.
2. Lawsuits or legal court proceedings
3. Request from law enforcement agencies
4. Worker's Compensation or similar benefit programs

You have rights:

1. You may ask us to communicate with you about your health and related business at a certain place and time. For example, you may ask that you only be called on your home number to set, confirm, or cancel an appointment. This means you would not be called at your place of employment.
2. You may ask that we limit what is discussed with certain individuals involved with you either financially or as caregivers, such as family members and friends. While we may not agree with your request, we will however try our best to honor it. This is as long as the terms are not in opposition to the law, not an emergency situation, or not necessary for treatment on your behalf.
3. You may review the information we have both medically and financially.
4. You may request a copy of your records at any time. However, we ask that you give us an ample amount of time to make copies. Please note that there is a charge for these desired copies.
5. You can ask that amendments be made to your records if you feel the information we have is incorrect or incomplete. These requests must be made in writing, and be sure to include the reason for these desired changes.
6. You have a right to make a copy of this notice. If any changes are made, they will be posted in the waiting room for you to read. You may also ask for any updates at the time of your appointment.
7. If you believe your rights have been violated, you may file a complaint with our Privacy Officer or with the Secretary of the Department of Health and Human Services. All complaints must be made in writing. Please note; filing a complaint will <u>not</u> change the level of care we are providing to you.

If you have any questions regarding this notice of our health information privacy policy, please contact our Privacy Officer, Salewa Taiwo by phone at (678) 610-7100.

The effective date of this notice is September 9, 2003.