

ALGOS BEHAVIORAL HEALTH SERVICES, INC.
NEW PATIENT INFORMATION RECORD

Today's Date:		Referred By:	
Patient Full Legal Name:			
Date of Birth: / /	Age:	Male / Female (circle one please)	
SSN: / /	Marital Status: Single / Married / Divorced / Separated / Widowed		
Address (physical):		Drivers License#:	
City:	State:	Zip Code(9 digits):	
Home Phone: ()	Cell Phone: ()	Work: ()	EXT#
Can confidential messages (i.e., appointment reminders) be left on your answering machine or voicemail? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, which is best: cell / home / work			
Email Address:			
Employer's Name:		Occupation:	
Address:	City:	State:	Zip:

PRIMARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Primary Insurance:	Phone # <i>(Located on the back of card)</i>
Subscriber ID#:	Group # :
Name of Policy Holder:	DOB:
Insured's Address:	<input type="checkbox"/> same as patient
City:	State: Zip Code(9 digits):
Policy Holder's Employer:	
Patient Relationship to Policy Holder: SELF / SPOUSE / CHILD / PARTNER	

SECONDARY INSURANCE

Please be sure to write down policy holder's information if you are not the policy holder

Name Of Secondary Insurance:	Phone # <i>(Located on the back of your card):</i>
Subscriber ID#:	Group # :
Name of Policy Holder:	DOB:
Insured's Address:	<input type="checkbox"/> same as patient
City:	State: Zip Code(9 digits):
Policy Holder's Employer:	
Patient Relationship To Insured: SELF / SPOUSE / CHILD / PARTNER	

EMERGENCY CONTACT PERSON

Name:	Relationship: Spouse / Brother / Sister / Mother / Father / Other:		
Home Phone: ()	Work Phone: ()	EXT:	

ALGOS BEHAVIORAL HEALTH SERVICES, INC.

Financial Policy

Thank you for choosing Algos Behavioral Health Services, Inc as your health care provider. The following is a summary of our financial policies. Please read the information carefully and sign or initial where noted below. We must obtain a copy of your driver's license and a current, valid insurance card. Failure to provide a current, valid insurance card and/ or information prior to your visit will result in payment due in full at the time of visit.

Initial below please:

_____ 1. **PAYMENTS. All applicable fees, deductibles, coinsurance, or co-pays must be paid at the time of your appointment.**

Initial We accept cash or credit card (Visa, MasterCard, or Discover). Unpaid accounts may be referred to an outside collection agency.

_____ 2. **CANCELLATIONS.** To reserve the hour of the clinician's time, we request a credit card to assure you of the availability of the doctor. There is a fee of **\$50.00** for a missed appointment or late cancellation. You can avoid this charge if you cancel 24 or more hours prior to the appointment. Your insurance carrier will not cover this fee.

_____ ** When applicable, for individuals scheduled for a testing appointment – you will be charged **\$50.00** for every hour of testing that is missed or not cancelled within 24 hours. For example, if you are scheduled for 3 hours of testing, and you cancel or do not show for that appointment time, you will be charged \$150.

_____ 3. **CHANGE OF INFORMATION.** You are responsible to provide us with any change regarding your address, phone number or insurance information as soon as possible.

_____ 4. **PRIVATE INSURANCE AUTHORIZATION AND INFORMATION RELEASE.**

Initial I, the undersigned, authorize payment of mental health benefits to Algos Behavioral Health Services, Inc for any services rendered. **I understand that I am financially responsible for any amount not covered by my insurance policy including but not limited to co-payments, co-insurance and deductibles.** Any payments denied by the insurance company will be forwarded to the undersigned, and the undersigned will be held responsible for payment. I also authorize Algos Behavioral Health Services, Inc to release to my insurance company any information concerning health care, diagnosis or treatment provided to me. This information will be used only for the purpose of evaluating and administering claims of benefits.

_____ 5. **POTENTIAL NON COVERAGE**

Initial Although other medical services may be covered by your insurance, this psychological service may not be covered and, in that case, you will be fully responsible for the entire amount. If the clinician is *out-of-network* with your insurance policy, you will be required to pay the full amount of the service rendered. We will NOT file claims for out-of-network services.

_____ 6. **NON-COMPLIANCE.** We reserve the right to discontinue care with you for non-compliance with any of the above policies.

_____ 7. The undersigned agrees that in the event of **default in payment** or if the account is placed with a collection agency for collection, he/she is responsible for reasonable attorney's fees, miscellaneous costs of collection, collection agency fees, and court costs, at the interest rate of 18% per annum.

**For all services rendered to minor patients, the adult accompanying the patient, or the policy holder, is responsible for payment.*

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

X _____
Signature of Patient OR Responsible Party if a Minor

Date: _____

Printed Patient Name

I WILL NOT BE USING INSURANCE FOR THIS SERVICE AND WILL PROVIDE ANOTHER FORM OF PAYMENT.

SIGNED: _____

DATE: _____

Algos Behavioral Health Services, Inc.

**Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D.,
Geetanjali Sharma, Psy.D., Sandy Zamora, LPC-S**

Health Insurance Portability and Accountability Act (HIPAA) Consent

General Notice

When seeking psychological consultation and/or treatment in this practice, **Protected Health Information (PHI)** will be gathered about you. This information may include a clinical history, medical history, personal information, and possibly performance/responses on psychological testing instruments.

Notice to Protect the Privacy of Your Health Information

A complete description of how your **PHI** may be used and disclosed is available for your review in the **“HIPAA Notice of Privacy Practices.”** A copy of this document is available at the reception desk. You may request a copy for your records.

Individual Rights

You have the right to restrict the uses and disclosures of your **Protected Health Information (PHI)** for the purpose of treatment and health care. A signed consent form is usually required. This practice is not required to agree to requested restrictions, but is bound by any restrictions to which it agrees.

You have the right to revoke this consent in writing, except to the extent that our practice has taken action on the reliance on this consent. You have the right to refuse to sign this consent. This practice has the right to refuse to provide the clinical services requested, if you refuse to sign the consent or if you revoke this consent at any time.

Your signature below acknowledges:

- You have read and understand this consent;
- You have agreed to have your **Protected Health Information (PHI)** used by this practice for the purposes of your consultation and treatment, to secure payment for your treatment, and for this practice’s psychological care operations;
- Prior to signing this consent, you were given the opportunity to review the practice’s **“HIPAA Notice of Privacy Practices;”**
- You are aware that you may now, or at any time in the future, request restrictions to the use and disclosure of your **Protected Health Information (PHI)**;
- This consent may be terminated at any time, with written request, except to the extent that this practice has taken action in reliance of the consent.

X _____
Signature of Client/Patient or Representative

Date

Authorization Form to Release Protected Health Information (PHI)

This form when completed and signed by you authorizes this psychological clinic to release Protected Health Information (PHI) from your clinical record to the person(s) you designate.

I hereby authorize my psychologist and/or clinical associate, Karri (Zumwalt) Lusk, Psy.D., Seán G. Connolly, Ph.D., Geetanjali Sharma, Psy.D. or Sandy Zamora, LPC-S and their practice management company, Algos Behavioral Health Services, Inc. and/or their administrative and clinical staff to release *the following specific clinical record and/or administrative/payment information:* (please list which information you want released)

_____ results of the psychological evaluation _____

**This information should be released to only the person(s) below:

I am requesting the release of this information for the following reasons:

at the request of the individual for continuing care for public agency use
 legal purposes other: _____

This authorization shall remain in effect until _____ (date),
or until _____
(specific purpose).

You have the right to revoke this authorization in writing at any time by sending such written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization, nor if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my psychologist or clinical associate generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

X _____

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

collection of insurance reimbursement and co-pay fees. Psychologists have the right to seek the services of a collection agency to obtain payment of past due balances.

My signature certifies that I have read and understand all the information provided by Algos Behavioral Health Services Inc., about the clinicians, the treatment to be provided, and the expense to be incurred. I hereby voluntarily give my informed consent for treatment. A copy of this authorization shall be considered valid. I understand that I will be informed of any changes concerning what is in this document and my consent will be obtained regarding these changes.

You are assured that the services will be provided in a professional manner, consistent with the rules and regulations of the Texas State Board of Examiners of Psychologists and the ethical principles of the American Psychological Association. Every effort will be made to provide services in a caring, supportive and trustworthy environment.

In addition to the specified procedure checked above, the initial goals of treatment will be established after the first or second session.

My signature certifies that I have been provided the opportunity to read/review the following relevant documents:

- **Notice of Privacy Practices**
- **Statement of Office Policies for Clinical Practice: Psychotherapy, Psychological or Neuropsychological Testing and Behavioral Health Assessments**

My signature certifies that I voluntarily give my informed consent to the clinical services offered by this psychological practice.

X _____
Signature of Client/Patient

Date

Signature of Responsible Party (if client is a minor)

Date