METRO BEHAVIORAL CARE, LLC
PATIENT'S INFORMATION

Today's Date: _______ /_______ /_________ Referred by & Telephone #:___________________

Primary Care Physician Name: ____________________________ Phone: ______________________

Patient Name:________________________ Driver's License # & State:________________________

Street Address: ____

City: _________________________ State: _____________ Zip Code: _______________

Preferred Contact Phone Number: (_____)_____-___________ Home/Work/Cell

Secondary Contact Phone Number: (_____)_____-___________ Home/Work/Cell

Race: ☐ Caucasian ☐ African American ☐ Hispanic ☐ Asian American
☐ American Indian ☐ Mixed ☐ Hawaiian

Date of Birth: ______/_____/_____ Age: ______ Sex: ☐ Male ☐ Female ☐ Other _________

SS# ______-______-______ Marital Status: Single/Married/Divorced/Separated/Domestic Partner/Widowed

Email: _________________________ Employer Name: ____________________ Full Time Student? ☐

Pharmacy Address: ______________________________ Phone Number: (___)_______-_______

Insurance Policyholder Name: ____________________________ Date of Birth: ______/_____/______

Relationship to Insured: ___________________________

EMERGENCY CONTACT IF PATIENT OVER 18/ RESPONSIBLE PARTY IF PATIENT IS UNDER 18:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other _______________

Name:____

Street Address: ____

City: _________________________ State: _____________ Zip Code: _______________

Mobile Phone: (_____)________-_________ Home Phone: (_____)________-_________

HIPAA PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have received a copy of the Notice of Privacy Practices of Metro Behavioral Care, LLC, effective 4/14/03.

Signature (patient or authorized representative): __________________________Date: ____________

Relationship/authority (if signed by an authorized representative): _____________________________

Please read the following Office Polices:

1. As a courtesy, our office will bill your insurance company. Any deductibles that have not been met, your co-insurance or your co-payment must be paid when services are rendered.

2. Any insurance changes must be reported to the office immediately. Any unpaid claims due to any reason; i.e. no authorization on file, lack of coordination of benefit information, no proof of student status, receipt of insurance information beyond the filing deadline, etc., will be the patient's responsibility. You will be required to pay the full cost of the visit.

3. Self-pay patients must remit full payment when services are rendered.

4. Any appointments missed or canceled without 24 hour prior notice will be billed in FULL and charged to the patient or responsible party. Insurance companies do NOT pay for missed appointments.

5. This office does not call in prescriptions for scheduled medication refills. Prescriptions will be given to you at the time of your scheduled appointment with the Provider. Office visits are required to monitor your progress.

6. If you require that a prescription be sent to a pharmacy due to any reason, you will be charged an administrative service fee of $10.00.

7. There is a $35.00 fee for a Non-Sufficient Fund check. Other service charges are posted in the office.

8. Telephone calls that require counseling and/or prolonged discussion will be charged at the discretion of the Therapist or Doctor.

9. Before any request for medical records, reports, letters and/or forms can be honored, the patients' account must be paid in full and in some cases a release of information form must be signed. There is a Service Charge for any paperwork completed by the Doctor or the Therapist.

10. Doctors are on call evenings and weekends for EMERGENCIES ONLY. Call backs for routine questions and prescription refill requests will only be done on the following business day.

11. Accounts that become delinquent may be turned over to a collection agency unless prior arrangements have been made with our accounts receivable staff.

12. If it is necessary for Metro Behavioral Care to institute legal proceedings against you to collect indebtedness due or to enforce any of the terms and conditions hereto listed, Metro Behavioral Care shall be entitled to recover from you reasonable attorney fees and collection costs.

*** I have read and agree to the above payment policies. I acknowledge and understand that I am responsible for all charges whether or not paid by my insurance company.

*** I hereby assign all medical benefits to Metro Behavioral Care, LLC and acknowledge that a photocopy of this assignment is as valid as the original.

*** I authorize Metro Behavioral Care, LLC to release confidential information regarding my medical condition, testing and/or treatment to my insurance company and/or managed care company in order to obtain payment/authorization/medication.

Patient's or Responsible Party's Signature:______________________________ Date: ______/______/___________

For your convenience, Metro Behavioral Care, LLC has a 24 hour answering service for emergencies and/or cancellations of appointments. You may call (770) 513- 7666 and leave a message.

Presenting Problems: ____

____

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____

____

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____

Have you seen a Psychiatrist previously? ☐ Yes ☐ No If you answered yes:

What is the Psychiatrist's name? ______________________________

Telephone number: (________) ________-__________ Date of last visit: _____/______/___________

List any medication(s) you are on:

____

____

____

Are you allergic to any medication? ☐ Yes ☐ No

If you answered yes, please list the medication you are allergic to and reaction:

____

____

Is there a family history of emotional/mental health problems? ☐ Yes ☐ No

If you answered yes, please list your relationship to the family member and describe problem:

____

____

Please note any other comments that you may have that may be beneficial to your evaluation/care:

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Clients' Rights and Responsibilities Statement

Statement of Clients' Rights

Clients have the right to:

- Be treated with dignity and respect.
- Fair treatment, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept private. Only where permitted by law may records be released without member permission.
- Easily access care in a timely fashion.
- Know about their treatment choices, regardless of cost or coverage by the member's benefit plan.
- Share in developing their plan of care.
- Information in a language they can understand.
- A clear explanation of their condition and treatment options.
- Information about their managed care company, its practitioners, services and role in the treatment process.
- Information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Clients' Rights and Responsibility policy.
- Know about advocacy and community groups and prevention services.
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Receive services that will not jeopardize their employment.
- Request certain preferences in a provider.
- Have provider decisions about their care made without regard to financial incentives.

Statement of Clients' Responsibilities

Clients have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers information they need. This is so providers can deliver the best possible care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider as soon as they know they need to cancel visits.
- Let their provider know when the treatment plan isn't working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.

My signature below shows that I have been informed of my rights and responsibilities. I understand this information and I have been offered a copy of this form.

____

Client's Signature   Date