

~* ~ **Welcome to Behavioral Health Associates** ~ * ~

Our mission is to help individuals, couples, and families with their behavioral health goals.

Thank you for choosing Behavioral Health Associates (BHA) as your provider for your mental health care.

The set of documents that follow this page, are explained below. Please RETURN THIS PACKAGE TO STAFF after you have read and signed all appropriate paperwork. Please note you will need to reference documents in your take-home package as you complete this. This package includes:

Patient Registration Form: Please complete this in its entirety so we will have all the necessary information to assist with your insurance billing. We also request that we be able to make a copy of your insurance ID card.

Authorization for Treatment, Payment, and Health Care Operations: This form gives permission for treatment and filing insurance. It also explains financial policies. *Please refer to the Office Procedures and Financial Policies in your take-home package.*

Acknowledgement of Receipt of Patient Notification of Privacy Practices: HIPAA requires that we obtain our signature, stating you received this document. *Please refer to the Patient Notification of Privacy Practices in your take-home package.*

Authorizations to Release Information: We have several authorizations to release information, including:

Authorization to Release Information to Primary Care Physician: This allows us to exchange information with your primary care physician regarding your treatment. If you do not want us to exchange information with our primary care physician, please sign the bottom portion of the release indicating that. If you do not have a primary care physician, please note that on the release and sign it.

Authorization to Release Appointment Information: To protect your privacy, we do not release any information to callers inquiring about your BHA visits. This authorization is provided so you can list the people we may talk to about appointments/rescheduling *only*. Please note that we will not talk with anyone other than you and/or those individuals listed on the authorization, nor will BHA staff share any information except scheduling with individuals listed on the release.

~ * ~ *Please let us know if you need assistance completing any of the paperwork.* ~ * ~

PATIENT INFORMATION

Name/ First		Middle		Last	
Address			City		State
Zip			State		Zip
Home Phone ()		Work Phone ()		Cell Phone	
SSN	Date of Birth	Age	Gender M F	Spouse's Name	

FINANCIALLY RESPONSIBLE PARTY (IF OTHER THAN PATIENT)

Name/ First		Middle		Last	
Address			City		State
Zip			State		Zip
Date of Birth	SSN		Employer		
Home Phone ()		Work Phone ()		Cell Phone ()	

EMERGENCY CONTACT

Name		Relationship	
Home Phone ()	Work Phone ()		Cell Phone ()

INSURANCE INFORMATION

Primary Insurance Company		Insurance Phone # ()	
Claims Address		City	
State		Zip Code	
Primary Cardholder's Name	ID #	SSN	Group #
Insured's Employer	Home Phone ()	Work Phone ()	Date of Birth

Secondary Insurance Company		Insurance Phone # ()	
Claims Address		City	
State		Zip Code	
Primary Cardholder's Name	ID #	SSN	Group #
Insured's Employer	Home Phone ()	Work Phone ()	Date of Birth

Behavioral Health Associates

Authorization for Treatment, Payment, and Healthcare Operations

By my signature below, and my presence at BHA, I hereby authorize BHA to provide mental health care.

I authorize *Behavioral Health Associates* to release to my insurance company, managed care organization, state agency/agencies, Health Care Financing Administration, Third Party Administration, and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable for related services.

I request that payment of Traveler's Railroad Retirement, Managed Care Organization, Third Party Administrators, Commercial Worker's Compensation, Liability, and/or any other insurance benefits be made on my behalf to *Behavioral Health Associates* for services furnished to me on my behalf by that provider.

I understand that I am financially responsible for deductible amounts, co-payments, co-insurance amounts, non-covered charges, and any and all balances not covered under a contractual write-off agreement between *Behavioral Health Associates* and my third party payor. My carrier's failure to pay does not release me from this responsibility.

I understand that *Behavioral Health Associates* participates and/or has contractual agreements with selected insurance plans/third party payors. I understand that unless otherwise restricted by a contractual agreement with such plans/third party payors, the entirety of the charges incurred will be transferred to the guarantor's responsibility if payment is not received from insurance within 60 days. I understand that I will be bound by any conditions of this agreement regarding guarantor/patient responsible charges. I understand that failure to meet my financial responsibilities in a timely manner may result in my account being turned over to a collection agency. I understand that I will be responsible for any collection, attorney, and/or court fees that may be involved in that process.

I understand that I am responsible for providing *Behavioral Health Associates* 24 (twenty-four) hours notice for cancelled appointments. Same day appointment cancellations are subject to a charge that shall be billed directly to me, and payment of any missed appointment charge will be my sole responsibility. I also understand that if I require prescriptions to be called in or written due to a missed appointment or late cancellation, there will be a charge. I also understand that I need to give a 72-hour notice for all medication refill requests.

I understand that all patient responsible charges are due prior to services rendered.

I have received a copy of the Office Procedures and Financial Policies and agree to abide by them.

Print Patient/Guarantor Name

Patient/Guarantor Signature (must be at least 18 years old or older)

Date Signed

Witness Signature

Date Signed

Behavioral Health Associates
6216 Airpark Drive
Chattanooga, Tennessee 37421

Authorization to Release Appointment Information

I, _____, authorize Behavioral Health Associates to release appointment scheduling information regarding _____ to the designated
(Patient's Name)

individuals listed below (provide name and phone number):

Can we leave voice mail messages with these people? Yes No

ONLY information specifically related to appointment times and scheduling will be released as a result of this signed release.

Please note that BHA cannot guarantee you will get a reminder call in the event we have difficulty reaching the people designated above. Also appointment reminder calls are provided as a courtesy, and we ask that you keep up with your appointment times in the event we're unable to call.

You have the right to revoke this authorization, in writing, at any time by sending such written notification to Behavioral Health Associates. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization.

Signature of Patient/Guardian

Date

Witness

Date

If this 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.

_____ If you do not want to be contacted to remind you of your appointment, please note that below.

_____ I do not want Behavioral Health Associates to make reminder calls for my appointment times.

_____ I want Behavioral Health Associates to contact me only at the following phone number(s):

Please Sign and Return to Staff

Behavioral Health Associates

6216 Airpark Drive

Chattanooga, Tennessee 37421

**ACKNOWLEDGEMENT OF RECEIPT OF
PATIENT NOTIFICATION OF PRIVACY PRACTICES**

I, _____, have been presented with a copy of Behavioral Health Associates' **Patient Notification of Privacy Practices**, detailing how my information may be used and disclosed as permitted under federal and state law, and I understand the contents of the Notification. By law, BHA is required to obtain your signature indicating you have received this document. Your signature below does not surrender any rights or confidentiality.

Signed: _____

Date: _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By: (name and title): _____

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**LATE CANCELLATION AND
MISSED APPOINTMENT POLICY**

Mental health care requires the collaborative effort of both you and your clinician. When you do not come to your scheduled appointment or cancel your appointment without the required 24 hour notice, not only do you miss an opportunity for treatment but you also deny someone else the opportunity as well. Whenever possible, a courtesy call will be made to remind you of your appointment, however, you are ultimately responsible for keeping your appointments. **Consequently, late cancellations and missed appointments will be charged a \$50 fee, and payment will be expected on or before your next schedule appointment.** Insurance companies do not pay for either late cancellations or missed appointments.

THE RESPONSIBILITY IS YOURS.

**I HAVE READ THE ABOVE AND AGREE TO ABIDE
WITH THIS POLICY.**

Patient's Signature _____

Staff or Clinician Signature _____

Date _____