NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

Date:_____ Referred by:_____

PATIENT INFORMATION - Please fill out completely.

Last Name:_____ First Name:_____M.I._____

Street Address_____

City:_____ State:_____ Zip:_____Gender (Circle): Female/ Male

Home Phone:_____Office Phone:_____ Cell:_____

Email:_____Date of Birth:_____ SS#:_____

Marital Status: (circle) Single / Married / Divorced / Widowed / Separated / Partnered / Other _____

Spouse's Name and daytime phone number:_____

Responsible Party: Provide information on who is responsible for paying for the service. ***(if different from patient)*** **Required if patient is a minor or legal guardianship is established.**

Name:_____ SS#:_____

Address:_____ Phone:_____

Relationship to Patient?_____

Emergency Contact: (Name/number/relation) _____

****Insurance Subscriber's Information (Spouse/Parent/Legal Guardian):**
Please provide insurance card and photo identification for copying

Name of Insured:_____ ID#: _____

Insured's date of birth:_____ SS#:_____ Relationship to Pt:_____

Name of Insurance Co:_____

Insurance number and address:_____Group #:_____

Confidentiality: Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, Neuro Behavioral Health Associates, LLC will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.

NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

PATIENT'S BILL OF RIGHTS/GENERAL POLICIES AND PROCEDURES

We are happy to provide you with this list of your rights as defined by the American Medical Association:

*Non Discrimination
*Information about your diagnosis prognosis and treatment plan
*Voluntary consent to treatment
*Approximate overall cost and billing information
*Right to seek another opinion
*Continuing healthcare after discharge from outpatient or inpatient care
*Privacy
*Third person present during treatment
*Identification of person providing service
*Active participation in decision making about your health status
*Knowledge of the need for continuation of care
*Knowledge of human experimentation
*Expected conduct in the outpatient setting
*Safety

Financial Policy

- Co-payments, co-insurance, deductibles and/or pre-service deposits are due at the time of service. Due to legal considerations this policy must be applied uniformly.
- Insurance may require pre-authorization. The appropriate payment is required at each visit. If the patient is a minor; payment is still required regardless of the relationship of the adult to the minor. In the case of children of divorced parents, payment is due at the time of service regardless of the terms of the divorce decree.
- NBHA will bill the insurance company on behalf of the patient.
- Benefits will be assigned.
- The patient authorizes NBHA to release any necessary information to process the insurance claims.
- Charges not paid by your insurance company within 180 days will become the patient's and/or legal guardian responsibility.
- Unpaid balances are referred to an outside collection agency.

General Officeal/Administrative charges (the following may apply and are expected upon registration prior to services being delivered):		
	Charge	Per
Missed appointment without notification by noon of the prior business day	$50.00	Appointment Missed
Request for Records/Forms/Paperwork (1-3 pages)	$25.00	Filled Request
Request for Records/Forms/Paperwork (4- 8 pages)	$50.00	Filled Request
Request for Records/Forms/Paperwork (8+ pages) Minimum	$100.00	Filled Request
Inpatient Forms/Paperwork	$50.00	Filled Request
Returned check fee **minimum**	$35.00	Return
Counselor/Therapy rate	$150.00	Session
MD/NP rate - follow-up/medication management	$125.00	Session
MD/NP rate - initial intake evaluation with or without medication management	$250.00	Session
MD Deposition Fee	$2,500.00	Per Day
Alternate Payment Arrangement: (Staff to specify, initial and date)		

APPOINTMENT POLICY Consultation with staff is by appointment only. Call us at 770.554.2999 to schedule an appointment. Each time that you call the office, our staff may confirm that our records have your correct daytime and evening telephone numbers as well as your correct mailing address. At each visit, please bring your insurance card and be prepared to pay the co-payment or unmet deductible. If you are considered self- pay patient, please be prepared to pay the agreed upon amount. Payment is required at the time of your appointment. Existing patients must complete new registration forms annually.

NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

CANCELLATION POLICY **Missed appointment without notification by noon of the prior business day carries a $50.00 Charge to be collected by office staff on the next appointment.**

EMAIL POLICY Unfortunately, we do not provide this service due to data breaches and the enormous volume of spam email. We do NOT accept emails for appointment cancellations nor prescription refill requests. ***Call the office for all request – PLEASE DO NOT USE EMAIL.***

TELEPHONE CALL POLICY If you are having a medical emergency please call 911. Routine calls and messages are given to the appropriate person as soon as possible, and every attempt is made to return telephone calls during regular business hours M-F 9am-5:30pm. There are times, however, when we cannot answer all calls within the same day they are received. Please leave a message and someone from our staff will call you at the earliest possible time.

TEST RESULT POLICY It takes a minimum of 3 days to receive test results. You will be notified of any ***abnormal*** test results. If you have not heard from the office staff within this time, please call the office.

HANDICAP ACCESSIBILITY There are several handicap accessible parking spaces in front of the entrance to the building. The office restrooms are ADA compliant. NBHA is smoke-free environment.

REQUEST FOR PAPERWORK (TO INCLUDE DISABILITY, FMLA, SCHOOL FORMS, etc) All request for completion of forms, to include disability and FMLA, will be reviewed by the Physician. It is at the Physician's discression as to whether requests are approved or denied. Due to the time it takes to review and/or complete all forms, fees are charged. The time period for completion of forms is between 2-4 weeks.

Fees are collected prior to the release of completed forms.

PRESCRIPTION REFILL POLICY The Psychiatrist will make the final determination for all prescription refill request.

1. No prescriptions are refilled for more than 90 days without an office visit.
2. No refill request via telephone will be accepted. Have the pharmacy fax the refill requests for review to 678.353.6979.
3. We will make every attempt to answer all Rx requests within 24-48 hours M-F.
4. Under no circumstances are certain psychotropic medications prescribed without an office visit.

TERMINATION OF SERVICES POLICY Patient may be discharged from services for the following reasons: **Treatment noncompliance**—The patient does not or will not follow the treatment plan.

- **Follow-up noncompliance**—The patient repeatedly cancels follow-up visits or is a no-show.
- **Office policy noncompliance**—The patient uses multiple health care practitioners to obtain refill prescriptions when prescribers have already established a set treatment plan for medications and refills.
- **Verbal abuse**—The patient or a family member is rude and uses improper language with office personnel, exhibits violent behavior, makes threats of physical harm, or uses anger to jeopardize the safety and well-being of office personnel with threats of violent actions.
- **Nonpayment**—The patient owes a backlog of bills and has made no effort to arrange a payment plan.
- **Revision of documents** – The patient alters written orders, documents, letters and forms (to include disability paperwork and prescriptions) that were previously completed by medical and clinical staff.

By signing, you are stating that you are in agreement with the policies for Neuro Behavioral Health Associates, LLC.

_____ _____

Patient/Legal Guardian/Parent Signature **Date**

NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

ASSIGNMENT FOR BENEFITS

I, _____ authorize Neuro Behavioral Health Associates, LLC (NBHA) to bill my insurance company for charges incurred during the course of my treatment and to provide any information necessary to process my claims and to collect payment. I authorize my insurance company to honor a photocopy of this authorization and to assign my insurance benefits for these charges to NBHA.

Signed:_____ Date:_____

Witness:_____ Date:_____

INFORMED CONSENT
(Adult Patients Only)

I, _____ have read and understand the policies and procedures for NBHA and I accept the conditions for receiving services from NBHA. I have reviewed a copy of NBHA 's HIPAA Notice of Privacy Practices and understand that a copy will be available at my request.

Signed:_____ Date:_____

Witness:_____ Date: _____

INFORMED CONSENT
(Adolescent Patients and/or Patients with Legal Guardians Only)

If you are signing this Informed Consent as it relates to seeking services for a minor child/adolescent, please answer the following questions (providing names and relationship of each with the adolescent):

With whom (both parents, one parent, other) does the child/adolescent reside?_____

Who has legal custody of the child/adolescent?_____

I (we)_____, parent(s) /legal guardian of_____
accept the conditions for receiving services from NBHA. I (we) have reviewed a copy of NBHA's HIPAA Notice of Privacy Practices and understand that a copy will be available at my request.

Signed:_____ Date:_____

Witness:_____ Date:_____

NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

PATIENT MEDICAL/MENTAL HEALTH HISTORY

Patient's Name:_____

Please **Circle:** (Please write N/A if not applicable)
Are you allergic to any medicines? **YES NO** If yes, which?_____
Have you ever had a seizure? **YES NO** If so, when was the last time?_____
Have you had a loss of consciousness? **YES NO** If so, when was the last time?_____
Are you currently being seen by a psychiatrist or psychotherapist elsewhere? **YES NO** If yes, please list below
Do you use alcohol? **YES NO** If so, when was the last time?_____
Do you engage in recreational drug use? **YES NO** If so, when was the last time?_____
Have you ever had an alcohol or substance abuse problem? **YES NO** If so, when?_____
Do you have an Advance Directive? **YES NO** If yes, are you willing to provide a copy to include in your medical records for NBHA? **YES NO**

Hospitalizations (for Psychiatric/Behavioral Health):

Year	Name of Hospital	Condition

Surgeries:

Year	Type

Other serious medical conditions:_____
_____

Current medications: (If MARS is available, please check □ and provide a copy to the receptionist)

Name	Dosage	Schedule

Please list the name and location of previous Psychiatrist seen in the last 3 years:
1._____
2._____
3._____

Please list the name and location of Psychotherapist below:
1._____
2._____
3._____

NEURO BEHAVIORAL HEALTH ASSOCIATES, LLC
REGISTRATION PACKET

367 Athens Hwy Ste 1050, Loganville, GA 30052, 770-554-2999 Office, 678-353-6979 Fax
1026 Twelve Oaks Drive Ste A, Watkinsville, GA 30677, 706-521-0999 Office, 770-679-6390 Fax

FAMILY MENTAL HEALTH HISTORY

Patient's Name:_____

Has anyone in your family (either immediate family members or relatives) experienced difficulties with the following? (Check any that apply and list family member, e.g., Sibling, Mother, Father, Uncle, etc. if applicable)

Difficulty	Yes	No	Family Member
Depression			
Bipolar Disorder			
Anxiety Disorders			
Panic Attacks			
Schizophrenia			
Alcohol Misuse			
Substance Misuse (please select if applicable) Amphetamines/speed Barbiturates Caffeine Cocaine Crack Cocaine Hallucinogens (LSD, etc.) Inhalants (glue, gas, etc.) Marijuana/Hashis Methadone Cigarettes/Nicotine PCP Prescription Other:_____ ○ _____			
Eating Disorders			
Learning Disabilities			
Trauma History			
Suicide Attempts			
Psychiatric Hospitalizations			
Phobias			