Behavioral Health Associates

6216 Airpark Drive
Chattanooga, TN 37421

Welcome To Behavioral Health Associates

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

The set of documents to follow this page are explained below. Please **RETURN THIS PACKAGE TO STAFF** after you have read and signed all appropriate paperwork. 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 and your driver's license.

Authorization for Treatment, Payment and Healthcare 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 your signature, stating you received this document. Please refer to Patient Notification of Privacy Practices in your take-home package.

Authorization 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 your 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 Limited Information: To protect your privacy, we do not release any information to callers inquiring about your BHA visits. The authorization is provided so you can list the people we may talk to about appointments/rescheduling only. Please note that we will not speak 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. If you are signing on behalf of a minor, please list any parent/guardian we may speak with, including yourself.

Census: We are required to ask these questions on the behalf of the government for census purposes. You can refuse to answer, BUT you must write that down as your response and sign the form.

Below is a list of providers in this office. Please check the name and licensure type of the provider you will be seeing. If you have questions regarding what type of license your provider has (or what it means), please ask the front desk or your provider directly.

Feel free to ask the front desk for assistance if you have any questions or need any additional help completing this form.

Medical Doctors (medication)
Dr. A. Lee Solomon, M.D.
Dr. Jon Cohen, M.D.
Dr. Prameet Bhushan, M.D.
Dr. Katie Goudelocke, M.D.

Psychologists (no medication)
Dr. Jim Brown, Ph.D.
Dr. Marci Pittman, Ph.D.
Dr. Tracy Schultz, Ph.D.
Dr. Marzi Radpour Wiley, Ph.D.

Master's Level Therapists
Kathy Scott, L.C.S.W.
Jennifer Gardner-Cummins, L.P.C.
Mary Kay Radpour L.C.S.W.

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Name/ First	Middle	Last		
Address	City		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
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 Employe	Home Phone ( )	Work Phone ( )	Date of Birth

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Authorization For Treatment, Payment & 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 organizations, state agency/agencies, Health Care Financing Administration, Third Party Administration, and/or Workers' 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 Operations, Third Party Administrators, Workers' Compensation, Negligence & 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 payer. My insurance 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 payers. I understand that unless otherwise restricted by a contractual agreement which such plans/third party payers, the entirety of the charges incurred will be transferred to the guarantor's responsibility if the 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 am responsible for any collection fees, attorneys' fees, and/or court fees that may be involved. Additionally I understand that interest shall accrue at the rate of one (1%) percent per month from the date my health insurance provider determines what amounts, if any, are not covered by the insurance provider.

I understand that I must provide *Behavioral Health Associates* no less than twenty-four (24) hours' notice to cancel an appointment. 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 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 medication refill requests

I understand that all patient responsible charges are due to prior services rendered.
I reviewed this document and shall comply.

_____
Print Patient/Guarantor Name

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

_____ _____
Witness Signature Date

Behavioral Health Associates
6216 Airpark Drive
Chattanooga, TN 37421
Ph: 423-899-0024 Fax: 423-899-5688

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. Any updates to this policy will be posted on our website and in our lobby for review.

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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Authorization to Release Healthcare Information to PCP

Patient's Name: _____ Date of Birth: _____

Legal Guardian's Name (if applicable): _____

I authorize Behavioral Health Associates to *(choose one):* **RELEASE / OBTAIN / EXCHANGE** records with

Name _____ Phone _____ Fax _____

Address _____

I authorize the release of :

___ Notification of Treatment at BHA
___ Coordination of Care Regarding Medication
___ Lab/Procedure Reports and Results
___ Progress Notes
___ Other Specific Information (use space below)
___ Psychiatric/Psychological Evaluation
___ Alcohol and/or Drug-Related Diagnosis and Treatment Notes
___ AIDS- and/or HIV-Related Diagnosis and Treatment Notes

_____

I am requesting Behavioral Health Associates to release this information for the following reasons ("at the request of the individual" is all that is required if you do not desire to state a specific purpose):

_____

_____

This authorization shall remain in effect until _____ _____

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*

_____ **I DO NOT have a Primary Care Physician.** ***(please initial)***

_____ **I DO NOT want my Primary Care Physician contacted.** ***(please initial)***

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Authorization to Release Limited Information

We offer an automated reminder call service that will contact you two business days ahead of time to remind you of your appointment. The automated call will give the message to anyone who answers or leave a voicemail if reached. Please take care to protect your phone from anyone you do not want to have this information.

Please note that BHA cannot guarantee you will get a reminder call in the event we have difficulty reaching you on the number designated below. 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.

Please choose one of the following options:

_____ No, I do not want BHA to make reminder calls for my appointment times.

_____ Yes, I want BHA to contact me only at the following phone number: _____

If there is anyone, other than the patient, that may call and check limited information on the account (example: check appointment time, pick up a prescription/samples, pay a bill, etc.) please list these names below (including parents/legal guardians if patient is under 18) and specify what information they may access. No other information other than what you list will be released. **NOTE: This is not a full medical records access request. That will still require a separate release of information to be signed. If no one other than patient, please state "NONE."

Name	Phone Number
What info may be released?	
Name	Phone Number
What info may be released?	
Name	Phone Number
What info may be released?	

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

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Census

Due to new federal guidelines, we are required to get the following information from every patient and record in your permanent record. These categories are defined by the U.S. Census standards. Please answer the following and return to the front desk. When this information is given to the federal government, it is reported in bulk with all other patients in this office. Otherwise, the release of this information will be treated as any other medical record (see Privacy Practices). Thank you.

Patient Name: _____

Date of Birth: _____ Gender: _____

Race: (please circle one):
American Indian or Alaska Native
Asian
Black or African American
Hispanic or Latino
Native Hawaiian or Other Pacific Islander
White
Unknown
Other (please specify): _____

Ethnicity: (please circle one)
Hispanic or Latino
Not Hispanic or Latino
Unknown

Preferred Language: (please circle one)
English
French
German
Mandarin
Portuguese
Spanish
Tagalog

Smoking Status: (please circle one)
Current Smoker
Former Smoker
Never Smoked

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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 _____