



# Jones Behavioral Health, Inc.

## NEW PATIENT INTAKE QUESTIONNAIRE

**PATIENT INFORMATION:**

Name (First/Middle/Last): \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
 Marital Status: \_\_\_\_\_ Employment Status: \_\_\_\_\_ Employer Name/Title: \_\_\_\_\_

NOTE: In order to prevent an interruption or delay in treatment services at Jones Behavioral Health, Inc., a Valid Georgia Driver's License or ID is needed prior to your initial appointment.

Physical Address Line 1: \_\_\_\_\_ Line 2: \_\_\_\_\_

City/State : \_\_\_\_\_ Zip Code : \_\_\_\_\_ # Yrs./Mo. at Address: \_\_\_\_\_

May we contact you by mail for any Announcements or information regarding treatment at Jones Behavioral Health, Inc.? (circle one) **YES / NO**

Home Ph. #: \_\_\_\_\_ Mobile Ph. #: \_\_\_\_\_ Work Ph. #: \_\_\_\_\_

May we contact you by phone for all appointment updates & reminders? (circle one) **YES / NO**

Email Address: \_\_\_\_\_

May we contact you by email? (circle one) **YES / NO**

**EMERGENCY CONTACT INFORMATION:**

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Phone #: \_\_\_\_\_

NOTE: Phone # needs to be DIFFERENT from any # listed as the Patient's Contact #s (above).

**MEDICAL HISTORY:**

Are you currently being treated for a Medical or Mental Health related condition? \_\_\_\_\_

If YES, please describe/list these conditions: \_\_\_\_\_

Name of Primary Care Physician: Office Location & Phone #: \_\_\_\_\_

Name of Psychiatrist: Office Location & Phone #: \_\_\_\_\_

Please list all current medications that you are prescribed (including any OTC meds): \_\_\_\_\_

What is your reason for seeking treatment from Jones Behavioral Health, Inc.?: \_\_\_\_\_

How did you hear about us?: \_\_\_\_\_

**FINANCIAL INFORMATION:** If you DO NOT have Health Insurance Coverage that will cover Substance Abuse &/or Mental Healthcare, please indicate by checking the box next to Self Pay below. If you DO have Health Insurance that covers Substance Abuse &/or Mental Healthcare sessions, please note the Name of the Insurance Co., along with all of the details required for Jones Behavioral Health, Inc. to bill your Insurance Company for your sessions on your behalf. If you are not sure whether or not our Insurance Company covers the services that we provide, please call the # listed on the back of your Insurance Card next to "Member Services".

- I have Private Insurance and I am the Policy Holder
- I have Private Insurance and I am a Dependent
- I have Insurance through my Employer
- I have Insurance through an Employer and I am a Dependent
- Self Pay (I do not have Insurance)  
(please visit [www.jonesbehavioralhealth.com](http://www.jonesbehavioralhealth.com) for a list of out-of-pocket costs)

**INSURANCE INFORMATION:**

Insurance Company Name: \_\_\_\_\_ Member ID: \_\_\_\_\_ Group #: \_\_\_\_\_

Copay listed on your card for "SP" (Specialist Office Visit): \_\_\_\_\_ Your Deductible Amount: \_\_\_\_\_

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Employer Name: \_\_\_\_\_

NOTE: In order to prevent an interruption or delay in treatment services at Jones Behavioral Health, Inc., your Insurance Card is needed prior to your initial appointment.

### CONFIDENTIALITY STATEMENT

We Thank You for using our services. There are several things that we want you to know before we discuss your reason for being here. At times it is difficult to discuss our personal problems with others. We want to assure you that protecting the confidentiality of your visit is a Priority. The Patient's Medical Records are inaccessible to anyone other than the Patient or a Legal Guardian/Power of Attorney, EXCEPT in the following situations, outlined in Georgia's Code of Ethics of the State Board of Examiners of Psychologists Ch. 510-4-.02-4.05, and in the numbers below. Your Provider has a Duty to Protect Identifiable Third Parties. This Duty is exercised by the Provider under discretionary disclosure (disclosing your confidential information in an effort to protect the Provider, the Patient and anyone who may be in harm's way.

1. Under O.C.G.A. 19-7-5, the GOCF and the PCAGA, this facility is Mandated to utilize the utmost discretion in the event that a child, elderly individual or any other party has been (is being) hurt by another person (to include the patient) and to report the child/elder abuse/neglect to DFACS.
2. Under O.C.G.A. 37-3-4, it is your Provider's duty to provide the care and treatment that acts on good faith when suspecting that a Patient may harm him/her self or someone else.
3. Your Provider may be required to present clinical records or give testimony in compliance with a Court Order or Subpoena.  
*Release of Clinical Information beyond the above circumstances will require written authorization from the Patient or Patient Representative.*

I authorize for services received under Jones Behavioral Health, Inc. to disclose any information pertinent to the above Georgia Laws. Any information obtained by the Insurance Company or Third Party Payer shall not be released to any other person unless I authorize it or Georgia Law orders it. I may request to receive a copy of all of the authorizations obtained, pursuant to administrative fees as notated at [www.jonesbehavioralhealth.com](http://www.jonesbehavioralhealth.com).

PATIENT (or Pt. Rep.) SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

## FINANCIAL POLICY

Thank you for choosing us as your mental healthcare provider. **Please understand that payment for any type of service rendered, is due at check-in for each session.**

**INITIAL VISIT:** The first visit is approximately 60 minutes long. The fee for this session is calculated at the prevailing rate if filing through an insurance company and is \$175.00 for all Self Pay Patients. Any fees that you are required to pay will be **due before your scheduled session.**

**EVALUATIONS:** Psychological testing/assessments usually require one or more visits, and are charges at the prevailing hourly rate. This includes time spent administering tests, scoring, interpretation, and report dictation and preparation. An additional fee may be charged for result consultations.

**INSURANCE FILING:** Our office provides the courtesy of filing your insurance claims for you. However, some insurance companies **may not cover your visit.** It is **your responsibility to contact your insurance company prior to your initial visit**, to determine if you provider is covered, and to see if the services that you are to receive are covered. We must emphasize that as providers, our relationship is with you, not your insurance company. **If your insurance company does not pay their portion within a reasonable amount of time (60 days), we must look to you for payment.** We accept cash, checks, and all major credit cards. Therefore, **we expect your account to be kept current.**

**USUAL, CUSTOMARY, AND REASONABLE RATE:** Our office is committed to providing the best treatment possible for our patients, and our fees are in line with the average fees for our area. **You are responsible for paying the bill in full** regardless of your insurance company's determination of the usual and customary rates. The exception to this policy is with any insurance / managed care company that has a formal contractual agreement with this practice or with your provider.

**PRE-CERTIFICATION:** Many insurance companies are now using managed care companies to administer and regulate their behavioral health benefits. **It is your responsibility to check with your insurance company prior to your appointments to determine whether your visits need to be pre-approved.** We will do everything we can to help your insurance get approval for whatever services you may need. In addition, we will keep your insurance/managed care company updated as required to keep your visits approved, and we expect you to do the same. It often takes contact from you to from our office to keep the process running smoothly.

**MISSED APPOINTMENTS:** **Unless cancelled at least 24 hours in advance**, our policy is to charge for a missed appointment, **the charge for a missed appointment is \$97.00** and this charge is **not payable to any insurance company.** Missed appointments include group therapy. All missed appointments not paid will be subject to finance charges. Keep in mind, if you call to cancel and/or reschedule your appointment, you **MUST** leave a message if you reach our voice messaging service. This message will ensure that you will not be charged a late fee. You may or may not receive an appointment reminder via email or phone call. Not receiving an appointment reminder is **NOT** grounds for voiding the no-show fee. It is up to **YOU** to remember your appointment date and time.

**Please help us serve you better by keeping scheduled appointments or canceling well in advance.**

**CHILDREN:** Parents/Guardians are responsible for their child's **conduct** while in our office, as well as for the child's bill. In a divorced or extended family, **the Parent/Guardian bringing the child for the treatment is responsible for payment.** The provider's relationship is with the Parent/Guardian who brings the child, not with the court-designated parent who may be responsible for medical bills. A receipt for payments made to this office will be provided to present to the court-designated parent for reimbursement to you.

**I HAVE READ AND UNDERSTAND THE ABOVE POLICY AND AGREE TO THE ABOVE TERMS AND CONDITIONS:**

\_\_\_\_\_  
**SIGNATURE OF PATIENT (or Responsible Party)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**DATE**

## Patient's Rights and Responsibilities

1. Patients have the right to be treated with personal dignity and respect.
2. Patients have the right to care that is considerate and respects their personal values and belief system.
3. Patients have the right to personal privacy and confidentiality of information.
4. Patients have the right to receive information about services, practitioners, clinical guidelines, and patient rights and responsibilities.
5. Patients have the right to reasonable access to care, regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
6. Patients have the right to participate in an informed way in the decision making process regarding their treatment planning.
7. Patients have the right to discuss with their practitioners the medically necessary treatment options for their condition regardless of cost or benefit coverage.
8. Patients have the right to have their family members participate in treatment planning. Patient over 12 years old has the right to participate in such planning.
9. Patients have the right to individualized treatment, including:
  - Adequate and humane services regardless of the source(s) of financial support,
  - Provision of services within the least restrictive environment possible,
  - An individualized treatment or program plan,
  - Periodic review of the treatment or program plan, and
  - An adequate number of competent, qualified, and experienced professional clinical staff to supervise and carry out the treatment or program plan.
10. Patients have the right to participate in the consideration of ethical issues that arise in the provision of care and services, including:
  - Resolving conflict,
  - Withholding resuscitative services,
  - Forgoing or withdrawing life-sustaining treatment, and
  - Participating in investigational studies or clinical trials.
11. Patients have the right to designate a surrogate decision-maker if the member is incapable of understanding a proposed treatment or procedure or is unable to communicate his or her wishes regarding care.
12. Patient and their families have the right to be informed of their rights in a language they understand.
13. Patients have the right to voice complaints or appeals about JBH or their provider of care
14. Patients have the right to make recommendations regarding JBH rights and responsibilities policies.
15. Patients have the right to be informed of rules and regulations concerning their conduct.
16. Information about the Quality Improvement Program of Jones Behavioral Health, Inc.
17. Patients have the right to be informed of the reason for any utilization management non-certification including the specific utilization review criteria or benefits provision used in the determination.
18. Patients have the right to have utilization management decisions made based on appropriateness of care. Jones Behavioral Health does not reward practitioners or other individuals conducting utilization review for issuing non-certifications of coverage or service.
19. Patients have the right to have access to their care management records.
20. Patients have the right to a humane treatment or habilitation environment that affords reasonable protection from harm, exploitation, and coercion.
21. Patients have the right to be free from physical and verbal abuse.

22. Patients have the right to be free from the use of physical restraints and seclusion unless it is determined that there are no less restrictive methods of controlling behavioral to reasonably insure the safety of the client and other persons.
23. Patients have the right to be informed about plan of treatment and to participate in the planning, as able.
24. Patients have the right to be promptly and fully informed of any changes in the plan of treatment.
25. Patients have the right to accept or refuse treatment, unless it is determined through established authorized legal processes that the client is unable to care of him or herself or is dangerous to him or herself.
26. Patients have the right to be fully informed of the charges for treatment.
27. Patients have the right to confidentiality of client records.
28. Patients have the right to have and retain personal property which does not jeopardize the safety of the client or other clients or staff, and have such property treated with respect.
29. Patients have the right to converse privately, have convenient and reasonable access to the telephone and mails, and to see visitors, unless denial is necessary for treatment and the reasons are documented in the client's treatment plan.
30. Patients have the right to be informed of the program's complaint policy and procedures and the right to submit complaints without fear of discrimination or retaliation and to have them investigated by the program within a reasonable period of time.
31. Patients have the right to have access to their own client records and to obtain necessary copies when needed.
32. Patients have the right to receive a written notice of the address and telephone number of that state licensing authority, i.e. the department, which further explains the responsibilities of licensing the program and investigating client complaints that appear to violate licensing rules.
33. Patients have the right to obtain a copy of the program's most recent completed report of licensing inspection from the program upon written request. The program is not required to release a report until the program has had the opportunity to file a written plan of correction for the violations as provided for in the rules.
34. Patients have the responsibility to give their practitioner and JBH information needed in order to receive appropriate care.
35. Patients have the responsibility to follow the agreed-upon treatment plan and instructions for care.
36. Patients have the responsibility to participate, to the degree possible, in understanding their behavioral health problems and developing with their practitioner mutually agreed upon treatment goals.

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**Signature of Patient / Client**

**Date**

## **Notice of Privacy Practices**

### **THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.**

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information (PHI). This notice of Privacy Practices describes how we use and disclose your PHI in accordance with applicable law and the NASW Code of Ethics. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by sending a copy to you in the mail upon request or providing one to you at your next appointment.

#### **HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU**

**For Treatment:** Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

**For Payment:** We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment related activities are making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for the purposes of collection.

**Required by Law:** Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

**Without Authorization:** Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations. The type of uses and disclosures that may be made without your authorization are those that are:

- Required by law, such as the mandatory reporting of child/ elder abuse or neglect or mandatory government agency audits or investigations ( such as the social work licensing board or the health department)
- Required by Court Order
- In the case of serious imminent threat to self and/or others, to include notification to any individual specifically threatened.

**Verbal Permission:** We may disclose your information to family members that are directly involved in your treatment with your verbal permission.

**With Authorization:** Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

**YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding PHI we maintain about you. TO exercise any of these rights, please submit your request in writing to our Privacy Officer at Alfred Jones Jr., LCSW, CAC:

- Right of access to Inspect and Copy. You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- Right to amend. If you feel that the PHI that we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- Right to Accounting of Disclosures. You have the right to request the accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- Right to Request Confidential Communication. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- Right to a Copy of this Notice. You have a right to a copy of this notice.

**COMPLAINTS**

If you believe that we have violated your privacy rights, you have the right to file a complaint in writing with either:

**Alfred Jones Jr., LCSW, CAC  
114 Pleasant Home Road, Ste. A  
Augusta, GA 30907**

**Office of Regulatory Services Complaints Department  
2 Peachtree Street  
Atlanta, GA 30303**

... or by calling (404) 657-5725 or 800-878-6442.

**We will not retaliate against you for filing a complaint.**

The effective date of this Notice is January 1, 2015

**I hereby acknowledge that I have received and have been given an opportunity to read and discuss Questions and/or Concerns regarding the above Notice of Privacy Practices.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

**Consent to Treatment:**

I, \_\_\_\_\_ (Patient or Signer), give my permission and consent to the above named Provider, Alfred Jones Jr. and any staff member who has been designated to facilitate my therapeutic session (or the session for the Patient of whom I am signing this consent on behalf) employed at Jones Behavioral Health, Inc. to provide services to myself and/or \_\_\_\_\_ (Patient's Name) who is/are my \_\_\_\_\_ (relationship to signer)

**I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my healthcare insurance provider.**

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Parent or Guardian Signature**

\_\_\_\_\_  
**Witness Signature**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Date**



**Jones Behavioral Health, Inc.**  
**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

JBH Account/Record Number (staff will complete): \_\_\_\_\_

I \_\_\_\_\_ hereby authorize **JONES BEHAVIORAL HEALTH, INC.**  
*(Patient or Authorized Personal Representative, Print Name)*

to disclose and release specific health information from my records *(records of the above named Patient)* to:

|                         |                                 |              |            |
|-------------------------|---------------------------------|--------------|------------|
| Recipient/Business Name | Address (Street/City/State/Zip) | Phone Number | Fax Number |
|-------------------------|---------------------------------|--------------|------------|

Please check if these records will be released to the patient/authorized person. Please include information of the party receiving the records above in lieu of the Business Name.

**MEDICAL INFORMATION TO BE DISCLOSED AND RELEASED TO THE ABOVE-NAMED PARTY:**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Face Sheet & Dx                    | <input type="checkbox"/> Medication Records & Hx | <input type="checkbox"/> Discharge and Aftercare Plan          |
| <input type="checkbox"/> Discharge Summary                  | <input type="checkbox"/> Treatment Plan          | <input type="checkbox"/> Patient Account Information (billing) |
| <input type="checkbox"/> Hx & Physical                      | <input type="checkbox"/> PCP Hx & Orders         | <input type="checkbox"/> Physician Weekly Progress Reports     |
| <input type="checkbox"/> Admission Date(s) & Patient Tx Hx  | <input type="checkbox"/> Progress Notes          | <input type="checkbox"/> Mental Status Exam/Psychosocial Eval. |
| <input type="checkbox"/> Psychological Evaluations          | <input type="checkbox"/> Pharmacy Records        | <input type="checkbox"/> Education Evaluation                  |
| <input type="checkbox"/> Medical Necessity Info. For all Rx | <input type="checkbox"/> Other (Specify): _____  |  |

Purpose(s) for the Release of the above documentation:

\_\_\_\_\_  
 \_\_\_\_\_

|   |  |               |
|---|--|---------------|
| _____<br>Patient Print Name                   | _____<br>Patient Signature                   | _____<br>Date |
| _____<br>JBH Staff Print Name                 | _____<br>JBH Staff Signature                 | _____<br>Date |
| _____<br>Authorized Representative Print Name | _____<br>Authorized Representative Signature | _____<br>Date |

***This Authorization was revoked by (name):*** \_\_\_\_\_ ***on:*** \_\_\_\_/\_\_\_\_/\_\_\_\_ **for reasons outlined below:**

Patient/Authorized Rep. Sign: \_\_\_\_\_ JBH Staff Sign: \_\_\_\_\_



Jones Behavioral Health, Inc. 2015  
 PO Box 204310 Augusta, GA 30917

Phone: (706) 364-3209

Fax: (706) 364-3259

[info@jonesbehavioralhealth.com](mailto:info@jonesbehavioralhealth.com)

\*Patient Agrees by his/her Signature to the Expiration Date of 1 (one) year, unless the information is a Financial Transaction, in which case that material would be retained and on file indefinitely. Termination of Release Agreement must be validated by Patient's (or Authorized Representative) Signature and Witnessed by a Member of the JBH Staff. This is located at the end of the Release Form.