Jones Behavioral Health, Inc.

NEW PATIENT/PARTICIPANT INTAKE QUESTIONNAIRE

Full Name:_____**SSN:** _____**DOB:** _____ **Age:** _____

Address *(# & St. Name)*: _____ *(Apt/Bldg #)*: _____

City_____ **State:** _____ **Zip Code:**_____

NOTE: ***In order to prevent Sessions &/or Billing to your Insurance Co., please provide JBH staff with a Valid GA Picture ID.***

May we contact you by mail for JBH announcements, appointment updates & reminders? ***(circle one)*** **YES or NO**

Home #: _____ **Cell #:** _____ **Work #:** _____

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

Email Address: _____

May we contact you by email for appointment updates and JBH events? ***(circle one)*** **YES or NO**

Emergency Contact:_____**Phone #:(____)____-_____Relationship:** _____

NOTE: The phone number for your Emergency Contact must be different from any other Contact # listed on this questionnaire.

Are you currently being treated for any Medical/Mental/Behavioral Condition? ***(circle one)*** **YES or NO**

If Yes, please list **all medicatons** (to include over-the-counter meds) that you are currently taking, along with the **Prescribing Physician's Name & Office Phone #***:* _____

_____

_____

NOTE: If some meds are prescribed by one Doctor and other's by another, please list all Prescribing Physicians. Thank You.

Please briefly describe your reason for seeking treatment (or the events that lead to treatment) at Jones Behavioral Health, Inc. today: _____

Have you ever been hospitalized for Mental or Behavioral Health reasons? ***(circle one)*** **YES or NO**

If Yes, please notate the date and the Physician &/or Hospital: _____

!!*IMPORTANT*!! IF YOU WOULD LIKE YOUR INSURANCE COMPANY BILLED FOR YOUR SESSIONS:

(if other than Pt.) ***NOTE: Must match ID & Addr. Insurance Co. has on File!!!***

Policy Holder Info.: Pt. Relation: _____ ***Full Name:*** _____ ***Street Addr.:*** _____

City:_____ ***St:*** ____ ***Zip:*** _____ ***Ph.#:*** _____ ***Alt. Ph.#:*** _____***DOB:***_____ ***SSN:*** _____

Insurance Co. Name:_____ **Member ID #:** _____**Grp #/Name:** _____**Eff..Date:** _____

Plan Name/Type: _____ **If there is a Copayment/Co-ins. Amt. listed on card next to SP or Specialist, the Amount: $** _____

Employer Name: _____ **Is Policy through Employer?** ***(circle one)*** **YES or NO**

If you would like to bill your sessions through your current Insurance Provider, Please fill in *ALL* of the required information below. You will also need to provide our staff with your Insurance Card(s). Until you are able to provide your Insurance Cards in either of the previous ways we will be unable to bill any sessions through your Insurance Company. When providing Insurance and Demographic Information over the telephone, please remember that until you are able to provide us with the actual form of ID and Insurance Card(s), we will not have had the ability to verify your identify or coverage and will be unable to hold the appointment, bill your Insurance Company or Both.

CONFIDENTIALITY STATEMENT

We thank you for deciding to use 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 that the Patient or a Legal Guardian/Power of Attorney, except in the following situations, oulined 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 excersicesd by the Provider under ***discretionary disclsure*** (discosing your confiential 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, ebderly individual or any other party has been (is being) hurt by another persion (to include the patient).report 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 himself or herself or someone else.
3. If we are required to present clinical records or give testimony as comply with a court order.

Release of Clinical information beyond the above circumstances will require your written authorization.

I authorization and eligibility for services received under an existing policy/policies. Such disclosures will be limited to information that is reasonably necessary. The information obtained by the Insurance Company or Third Party Payer shall not be released to any other person unless I authorize. I may request to receive a copy ÔÈÀ ÓÁÉÄ authorizationì ÐÕÒÓÕÁÎÔ ÔÏ ÁÄ ÍÉÎÉÓÔÒÁÛÉÖÅ ÆÅÅÓ ÔÈÁÔ Í shall be valid during the period that all invoice/claims are being processed.

_____ _____/_____/_____

SIGNATURE OF PATIENT (or Patient Representative) **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 $160.00 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 he 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 at the **rate of a normal office visit** *($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 trails.
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.

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.
- Tight 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 therapeautic 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**