Acclaim Behavioral Services, LLC

Demographic Face Sheet

PLEASE PRINT

Patient's Name: (Last Name, First Name, Middle Initial)	Patient's Date of Birth: (MM/DD/YY) / / Gender: ☐ Male ☐ Female
Patient's Address: (No., Street)	Patient's Social Security Number:
City, State, Zip Code:	Telephone: Work ( ) Home ( ) Cell ( )
Patient Status: Single ☐ Married ☐ Other ☐ Employed ☐ Full Time Student ☐ Part-Time Student ☐	Is Patient's Condition Related to: A: Employment (Current or Previous) Yes ☐ No ☐ B: Auto Accident Yes ☐ No ☐ C. Other Accident Yes ☐ No ☐

INSURANCE INFORAMATION:

Insured's Name: (Last Name, First Name, Middle Initial)	Insured's Insurance ID Number:
Insured's Address: (No., Street)	Insured's Group Number:
City, State, Zip Code:	Insured's Social Security Number:
Employer Name:	Insured's Date of Birth: (MM/DD/YY)
Primary Insurance Company Name: (Behavioral Health Ins. Name) ______________ Patient's ID No. ______________ (if different than above)	Patient's Relationship to the Insured: Self ☐ Spouse ☐ Child ☐ Other ☐
Type of Insurance Plan: Co-Pay ☐ Deductible ☐ Percentage Plan ☐ HSA ☐ Do you need a referral from your PCP Yes ☐ No ☐ What is the Behavioral Health Toll-Free Number ____(_______)______________	Who is your Pediatrician or Primary Care Physician? Name: ______________ Tel.: ______________
Do you need a Pre-Authorization Yes ☐ No ☐ If so, Auth. #:______________	Who Referred you to this Practice?
The Number of Sessions Approved:	If you have a Deductible Plan, What is that amount? $__________ How much has been met to date? $__________
What is your Co-Pay Amount Per Session?	If applicable, what are the Start and End Dates of your authorization? ______________

Acclaim Behavioral Services, LLC
2400 Tamarack Avenue, Suite 201
South Windsor, CT 06074
Phone: (860) 432-1199
Fax: (860) 432-1152

Patient Insurance Checklist

Patient Name________________________________ Name of Policy Holder___________________________________

Policy Holder's Social Security #______________________ Policy Holder's date of birth _______________________

Please provide the following answers as they apply, by ***calling the toll-free member services number*** on the back of your insurance ID card. [usually under mental health or behavioral health services]

1. What is your co-pay for outpatient mental health services [per session] $________________?

2. Do you have a deductible? YES or NO

   A. If so, what is that amount $ ______________? To date, how much has been met? $________________

   B. After the deductible is met, how much of the fee are you then responsible for? _________________

   C. When does the deductible renew? ____________________________________

3. How many sessions are you authorized for (per year)? ________________

For office use only:

90837 approved? (UBH only): YES or NO

All of this information must be supplied in order to submit claims to your Insurance carrier. ***If you do not obtain this information or follow your insurer's procedures, any unpaid balance will be your responsibility. Also be certain to notify my office of any carrier/benefit changes throughout the year. New insurance will require all information to be updated.*** Thank you!

Signature of responsible party______________________________________ Date_____________________

ACCLAIM BEHAVIORAL SERVICES, LLC.

Release of Information

I hereby authorize an exchange of the following protected information of:

Patient Name:____ D.O.B._______________

Between: **Acclaim Behavioral Services, LLC** and ____
2400 Tamarack Avenue, 2nd Floor ____
South Windsor, CT 06074 ____
Phone: (860) 539-6779 ____

PURPOSE OF RELEASE: _Coordination of Care____

SPECIFIC INFORMATION TO BE RELEASED:

History and Physical
Psychiatric Records
Outpatient Treatment Notes
Phone Communication between parties
Social / Emotional / Functioning at Work
School Attendance Records
Psychological and / or Educational Evaluations
Medical Records
Other (specify) ____

DATES: Covered by this authorization are from: _______________________to_______________________

It is my understanding that this information will be used solely for the purpose described above. I understand that the information which I am authorizing to be released may include psychiatric diagnoses and or drug/alcohol related information.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule.

I understand that I may revoke my permission in writing at any time. Any actions Acclaim Behavioral Services, LLC may have taken before receiving notice that the consent has been revoked would not be covered by the revocation. I hereby release, Acclaim Behavioral Services, LLC and its duly authorized agents from all legal responsibility or liability for the release of information indicated and authorized herein.

I understand that my care provider generally may not condition mental health services upon my signing an authorization unless the mental health services are provided for the purpose of creating health information for a third party.

A fax or photocopy of this form is considered valid.

Patient’s Name: _______________________________________ DOB: ___________________

Patient or Responsible Party Signature: ______________________________ Date: ___________________

Relation to Patient: Patient Spouse Legal Guardian Conservator Other _________________

Witness: ____ Date: ____________________

ACCLAIM BEHAVIORAL SERVICES, LLC.

Fee Agreement and Cancellation Policy

By signing this document, I am willfully entering into a contract with Acclaim Behavioral Services, LLC regarding payment of fees for services rendered.

1. **FINANCIAL RESPONSIBILITY**:

I acknowledge full financial responsibility for services rendered by Acclaim Behavioral Services, LLC. Payment of these charges is collected at the start of each session. I understand that any charges incurred by Acclaim Behavioral Services, LLC associated with collection of payments (e.g., insufficient funds, collections costs, denial of insurance benefits) will be forwarded on to me.

2. **CANCELLATION / NO SHOW POLICY:**

As appointments that are cancelled with less than 24 hours notice typically cannot be filled with other patients, **any cancellation made with less than 24 hours notice or any appointment missed will result in your being charged for the appointment**. Rates are $50.00 for appointments cancelled with less than 24 hours notice and half the cost of the session fee for any appointment that is missed without notification (**minimum** charge of $50.00). These charges are not billable to any insurance company. Appointments cancelled due to inclement weather, patient or family illness or family death will not incur a charge.

3. **SERVICE TERMINATION:**

I understand that if I do not make payments for services, that Acclaim Behavioral Services, LLC reserves the right to suspend treatment, upon appropriate notice, and will assist in making a referral elsewhere. If treatment is to be terminated your therapist will treat you for a brief period of time until another provider is identified, and he or she will send copies of your record to your new provider upon receipt of your authorization to do so. Even if treatment is to be terminated or transferred elsewhere, in the event of an emergency your therapist will provide appropriate and necessary care.

4. **FORENSIC OR COURT-RELATED SERVICES:**

I understand that should there be any court or forensic involvement needed as a result of treatment at Acclaim Behavioral Services, LLC, that there is a separate financial obligation that I will be fully responsible for. I understand that these costs will not be covered by my insurance carrier and that the entire cost will be solely my responsibility. These fees will be in force even if these forensic services were not initiated by me. Should there be any reasonable possibility that forensic work will be required during the course of treatment here I will inform my provider as soon as is feasible. Fees for these specialized services will be disclosed to me by my therapist and are also disclosed on the Acclaim Behavioral Services, LLC website: www.acclaimbehavioral.com

I have read and fully understand and agree to the above fee agreement and cancellation policy.

Patient Name: ____ DOB: ____________________

Responsible Party's Name: ____

Responsible Party's Signature: ____ Date: ________________

Responsible Party's Social Security #: ____

Witness Signature: ____ Date: ____________________

Acclaim Behavioral Services, LLC
Evergreen Walk / ECHN Medical Campus
2400 Tamarack Avenue, Suite 201
South Windsor, CT 06074
Tel. 860-432-1199
Fax 860-432-1152

Co-Pay and Deductible Policy

We at Acclaim Behavioral Services, LLC want to make sure that patients and therapists are on the same page as to what each patient is financially responsible for per session. Therefore, we will be following up with your insurance company to verify whether your plan involves a deductible payment, copayment, or neither. It is incredibly important for you, as a patient, to fully understand the coverage and benefits associated with Mental Health Services under your insurance plan so we strongly advise you to contact your insurance company as well.

Effective March 30, 2015:

Deductible Patients

If you have a deductible plan and your deductible has been met at the time of your session, no payment will be required from you (unless your plan states you are still responsible for a percentage or portion of the session fee). However, if your deductible has not been met then payment for your session is expected **prior to rendering services.** Psychotherapy services will not be given without payment (unless the session meets criteria for an emergency session). Cash, check, or credit cards are accepted for deductible payments.

Copayments

All copayments are due **prior to rendering services.** Psychotherapy services will not be given without payment (unless the session meets criteria for an emergency session). Cash or Check only.

Thank you.

Signature of Responsible Party____ Date _____________

IV. Questions and Complaints

- If you have questions about this notice, disagree with a decision made about access to your records, or have other concerns about your privacy rights, you may contact Steven Bonanno, Psy.D. 860-539-6779.

- If you believe your privacy rights have been violated and wish to file a complaint with the office, you may send your written complaint to Steven Bonanno, Psy.D. at 860-539-6779, 2400 Tamarack Ave., South Windsor, CT, 06074.

- You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services in Washington, D.C.

- You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

Acclaim Behavioral Services, LLC
2400 Tamarack Avenue, 2nd Fl.
South Windsor, CT 06074
Ph: (860) 539-6779

ACCLAIM BEHAVIORAL
SERVICES, LLC.

Notice of Policies and Practices to Protect the Privacy of Your Health Information.

Effective: October 1, 2003

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

I. Uses and Disclosures of PHI for Treatment, Payment, and Health Care Operations

- Protected Health Information (PHI) is any information in your health record that could identify you. Members of our workforce may only access the minimum amount of PHI that they need to complete their assigned task.

- When you see one of our providers, he or she will use and disclose your PHI to treat you, to obtain payment for services and to conduct normal business known as health care operations.

  – *Treatment* includes documentation of each visit. This documentation may include test results, diagnoses, medications, interventions and your response to interventions. Typically this information is used to coordinate and manage your health care services. An example of treatment would be when your therapist consults with your primary care physician.
  - *Payment* is when your therapist discloses your PHI to your health insurer to obtain reimbursement for your mental health services or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of the practice. Examples of health care operations are quality assessment and improvement activities, business-related matters, such as audits and administrative services, and case management and care coordination.

II. Disclosure Without Consent or Authorization

- Typically, any release of PHI for purposes outside of treatment, payment, and health care operations require your signed consent or authorization.

- Your therapist may use or disclose PHI without your consent or authorization in the following circumstances:

  - *Abuse or Neglect*: To protect children and elderly persons from physical or emotional abuse or neglect, our therapists are legally required to report any concerns to the appropriate state agency (e.g., DCF).
  -*Health Oversight:* Should your therapist be the focus of an inquiry, federal and state agencies have the power to subpoena relevant records.
  -*Serious Threat to Health or Safety:* If you communicate to your therapist an explicit threat upon an identified person, he must take reasonable precautions.
  -*Worker's Compensation:* If you file a workers' compensation claim, your records relevant to that claim will not be confidential to entities such as your employer, the insurer and the Division of Worker's Compensation.

III. My Responsibility

- Our therapists are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices. We reserve the right to change the privacy policies and make the new practices effective for all the information he maintains. Revised notices will be communicated and copies will be made available.

IV. Your Rights

You have the right to:

- Request that your therapist restrict how he or she uses or discloses your medical information (he is not required to abide by your request).

- Request that your therapist uses a specific telephone number or address to communicate with you.

- Inspect and/or copy PHI and psychotherapy notes in your mental health and billing records. Your therapist may deny access to PHI under certain circumstances, but you have the right to have this decision reviewed.

- Obtain a paper copy of this notice upon request.

- Receive an accounting of how your PHI was disclosed for which you have neither provided consent nor authorization.

- Request an amendment of PHI for as long as the PHI is maintained in the record. Your therapist may deny the request.

- Register a complaint.

Acclaim Behavioral Services, LLC

Notice Receipt

By signing this form, I acknowledge that I have received, read and understand the brochure "Notice of Policies and Practices to Protect the Privacy of Your Health Information" provided by Acclaim Behavioral Services, LLC. The Notice describes how mental health and medical information about me or my child may be used and disclosed and how I can get access to this information.

Patient's Name: _______________________________________ DOB: ____________________

Responsible Party's Name: ____

Responsible Party's Signature: _________________________________ Date: _______________

Relation to Patient: Parent Self Legal Guardian Foster Parent Other _____________

Witness: ____ Date: _____________________

2400 Tamarack Avenue • South Windsor, CT 06074 • (860) 539-6779