VILLA RICA BEHAVIORAL HEALTH, PC
REGISTRATION FORM

PATIENT INFORMATION

Patient Name: (Last, First, MI)		Today's date:
Street Address:	City, State, Zip	Home Phone: ( )
Birth Date:	Sex: ☐ Male ☐ Female	Cell Phone: ( )
Emergency Contact, Phone Number:		Emergency Contact Relationship:
Preferred Contact Number(s) for future appointments, lab results, etc,: ☐ Home ☐ Cell ☐ Work		Referred by:

If Patient is Minor, complete the next section

Mother name:	Father name:
Mother address (if different):	Father address (if different):
Mother birth date:	Father birth date:

Insurance Information

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this patient covered by insurance? ☐ Yes ☐ No

Name of **Primary** insurance company:

Policy holders name:	Policy holder address (if different):	Birth date: / /	Group no.:	Policy no.:	Effective date:

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Name of **Secondary** insurance (if applicable):	Policy holder name:	Group no.:	Policy no.:

Policy holder address (if different) City, State, Zip

Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other Birth date: / /

The above information is true to the best of my knowledge. I, the undersigned, authorize Dr. George Bailey to evaluate and treat my child. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Villa Rica Behavioral Health, PC or insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Villa Rica Behavioral Health, PC

New Patient Information

Name: _____

Date: _____

In order to be of the most assistance to you, please complete the following:

1. Please put into **one sentence** the reason you are here today. **This information, in your own words, is required by your insurance company:**

   _____

   _____

   Examples" "She is depressed." "He is acting out at home and school." "He is feeling suicidal."

2. Provide brief summary of the problems or concerns you are having:

   _____

   _____

   _____

   _____

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   _____

   _____

   _____

3. Please circle the type of assistance you think you may need:

Psychiatric Evaluation	Second opinion	Psychotherapy
Medication	Family Counseling	Other

Villa Rica Behavioral Health, PC

Treatment of Minors

The following individuals have my permission to bring my child to the office for treatment of routine medical care.

Patient Name:	Date:
Name:	Relationship to patient:
1.	
2.	
3.	
4.	
5.	

Parent/Guardian signature

Date

NOTICE OF FINANCIAL RESPONSIBILITES

Insurance Information

As a courtesy, Villa Rica Behavioral Health verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if the plan pays differently that quoted, the insurance company will honor what was paid, not the benefit quoted over the phone.

Payment

All co-payments, co-insurance, and deductibles must be paid at the time of service. Although we are contracted with an insurance carrier, our services may not be covered by your particular plan. Please remember you are 100 percent responsible for all charges incurred. A physician referral and our verification of insurance benefits are not guarantee of payment from the insurance carrier. If there is a remaining balance after the claim is paid, you will be billed for any outstanding balances.

Method of Payment

We accept cash, checks, and all major credit cards.

Returned Checks

A $35.00 fee will be charged for any returned checks. We will be unable to accept your checks for any services thereafter.

Divorced, Separated, or Blended Families

Villa Rica Behavioral Health, PC will not become involved in any agreement, understanding and/or court orders. As always, **payment is expected at time of service**. If reimbursement is to be from absent parent, it is **your** responsibility to collect reimbursement, not Villa Rica Behavioral Health, PC.

Insurance Changes

If there are ANY changes in your insurance, you are required to provide that information to our office. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges.

Secondary and Tertiary Plans

We will bill your secondary and, if applicable, Tertiary plans as a courtesy.

Non-covered Services

Any service not covered by your existing insurance coverage will require payment in full at the time services are rendered or upon notice of the insurance company.

Self-Pay
If you do not have insurance coverage, you are required to pay in full at the time services are rendered.

Missed Appointments/ Late Arrivals
Compliance with your prescribed plan if care is necessary for success in your healthcare. If you are unable to keep a scheduled appointment, please cancel or reschedule your appointment at least 24 hours prior to scheduled appointment to avoid a service charge. There is a $50 service charge for the missed appointment. Patients who habitually fail to keep scheduled appointments and do not give 24 hours' notice may be terminated from the practice. See practice guidelines for additional information.

Medical Records
Medical records requests will be processed upon receipt of a signed medical release. There may be a charge.

Signature below acknowledges you have received a copy of our Notice of Financial Responsibilities.

_____ _____

Printed Name of Patient/Guarantor (if minor) Date

_____ _____

Signature of Patient/Guarantor (if minor) Date

Villa Rica Behavioral Health, PC

Patient Consent Form

Our notice of Privacy Practices provides information about how we use and disclose protected health information about you. The Notice contains a patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

_____ _____

Signature of Patient/Guarantor (if minor) Date

_____

Printed Name of Patient/Guarantor (if minor)

Villa Rica Behavioral Health, PC

Practice Guidelines

1. One to two days prior to a scheduled appointment, a member of the VRBH office staff will call to notify you of an upcoming appointment.
2. You will need to confirm your plans to keep the appointment or the need to cancel or reschedule the appointment.
3. If the appointment is NOT confirmed 24 hours prior to the scheduled time, the appointment may be cancelled.
4. If you are not able to speak with the caller, you may leave a voice mail confirming whether or not you will be able to keep your appointment. This voice mail must be left no later than 24 hours prior to the scheduled appointment. If appointment is cancelled, you will need to call the office during business hours to reschedule.
5. If you confirm the appointment and do not show up for the scheduled, confirmed appointment, you will be charged $50 for the missed appointment.
6. You will not be rescheduled for future appointments or receive refills on medications until arrangements are made to pay the missed appointment fee.
7. If this happens three (3) times within a year, you may be dismissed from the practice.
8. If you arrive more than five (5) minutes late for your scheduled appointment, you may be asked to reschedule the appointment. If you choose not to reschedule, you will only be seen for the time remaining in the scheduled time.

Medicaid Patients:
Federal regulations do not allow charging for missed appointments; however, you have the responsibility of keeping appointments you have scheduled. The same guidelines as outlined above will apply excluding the additional charge.

_____ _____

Signature of Patient/Guarantor (if minor) Date

_____

Printed Name of Patient/Guarantor (if minor)

Patient Name:_____

U.S. Department of Health & Human Services

Improving the health, safety, and well-being of America

Health Information Privacy

Does the HIPAA Privacy Rule permit health care providers to use e-mail to discuss health issues and treatment with their patients?

Answer:

Yes. The Privacy Rule allows covered health care providers to communicate electronically, such as through e-mail, with their patients, provided they apply reasonable safeguards when doing so. See 45 C.F.R. § 164.530(c). For example, certain precautions may need to be taken when using e-mail to avoid unintentional disclosures, such as checking the e-mail address for accuracy before sending, or sending an e-mail alert to the patient for address confirmation prior to sending the message. Further, while the Privacy Rule does not prohibit the use of unencrypted e-mail for treatment-related communications between health care providers and patients, other safeguards should be applied to reasonably protect privacy, such as limiting the amount or type of information disclosed through the unencrypted e-mail. In addition, covered entities will want to ensure that any transmission of electronic protected health information is in compliance with the HIPAA Security Rule requirements at 45 C.F.R. Part 164, Subpart C.

Note that an individual has the right under the Privacy Rule to request and have a covered health care provider communicate with him or her by alternative means or at alternative locations, if reasonable. See 45 C.F.R. § 164.522(b). For example, a health care provider should accommodate an individual's request to receive appointment reminders via e-mail, rather than on a postcard, if e-mail is a reasonable, alternative means for that provider to communicate with the patient. By the same token, however, if the use of unencrypted e-mail is unacceptable to a patient who requests confidential communications, other means of communicating with the patient, such as by more secure electronic methods, or by mail or telephone, should be offered and accommodated.

Patients may initiate communications with a provider using e-mail. If this situation occurs, the health care provider can assume (unless the patient has explicitly stated otherwise) that e-mail communications are acceptable to the individual. If the provider feels the patient may not be aware of the possible risks of using unencrypted e-mail, or has concerns about potential liability, the provider can alert the patient of those risks, and let the patient decide whether to continue e-mail communications.

Parent/Guardian

Signature_____Date_____

Consent and Guidelines to Use Email at Villa Rica Behavioral Health, PC

As a supplement to your in-office appointments, you may choose to use email to communicate with this practice. Below are policies outlining when and how email should be utilized to maintain your privacy and to enhance communication. This is also your consent to using email.

Your decision to utilize email is strictly voluntary and your consent may be rescinded at any time. Email communications will be accessed by Dr. Bailey only.

If you prefer to use an encrypted, secure email system, that is also available at this practice. Ask Dr. Bailey how to access the secure system.

The best use of email is to report progress on the use of medications, side effects, behaviors of concern, questions about treatment and any other issues of concern. It may also be useful for transmitting school or other forms relating to treatment.

Please do not use email for the following:

1. Requests for prescription refills. These need to be phoned into the office staff so that the requests can be documented in the chart and who made the request. You may leave a message on voice mail regarding a need for refills.
2. Emergency messages
3. Reports of potential injury to self or others
4. Serious or life-threatening symptoms

What are the potential risks for using email?

1. Email may be seen by unintended viewers if addressed incorrectly
2. Email may be intercepted by hackers and misused
3. Someone posing as you could access your information
4. Email can be used to spread computer viruses
5. There is a risk that emails may not be received by either party in a timely manner as it may be caught by Junk or Spam filters
6. Emails are discoverable in litigation and be used as evidence in court
7. Email can be stored and circulated by unintended recipients
8. Statements made by email may be misunderstood or misinterpreted, thus causing miscommunication that could result in less than optimal treatment
9. There may be an unanticipated time delay between messages being sent and received

What happens to email messages?

1. Depending on the nature of the email, some emails may be printed out and maintained as a permanent part of the medical record
2. As part of your permanent medical record, messages may be released along with the remainder of your record upon your authorization or when the doctor is otherwise legally required to do so

What are my obligations?

1. I must let Dr. Bailey know if my email address changes from the one previously used.
2. If I do not receive a return message from Dr. Bailey in a reasonable time frame, I will contact him by telephone.
3. I will use email communication only for the purposes stated above
4. I will advise Dr. Bailey in writing in the event that I change my mind and no longer want to continue communicating by email

What general steps can you take to protect your email privacy?

1. Do not use an unsecure computer, such as a work computer, because such computers may be monitored and emails read
2. Do not use a shared email account to transmit personal messages
3. Log out of your email account if you will be away from your computer
4. Carefully check the addresses before using "send" to ensure that you're sending a message to the intended receiver. For example, our email address is ***gbailey@vrbh.net*** not gbailey@vrbh.com
5. Avoid writing or reading emails on a mobile device in a public place
6. Avoid accessing email on a public Wi-Fi hot spot

Consent to Use Email at Villa Rica Behavioral Health, PC

By signing below, I consent to the use of email communications between myself _____ and George W Bailey, M.D. I recognize that there are risks involved in the use of emails and despite Dr. Bailey's best efforts, he cannot absolutely guarantee confidentiality. I understand and accept those risks and the policies for email use outlined in this form. I further agree to follow these policies and agree that, if I failed to do so, Dr. Bailey may decline allowing me to use email to communicate with him. I also understand that I may withdraw my consent to communicate by this email at any time by notifying Dr. Bailey in writing.

Name of patient: _____ Date: _____

Signature of patient or guardian:_____

VILLA RICA BEHAVIORAL HEALTH, P. C

Due to recent changes in handling patient information and insuring patient confidentiality, we ask that you complete the following information.

Please list those people you authorize to pick up prescriptions for you and/or your child when you are not available to come in. Please try to list at least two (2) persons.

1._____

Name Phone Number

2._____

Name Phone Number

3._____

Name Phone Number

Pharmacy Information

Name_____

Phone _____