

Heritage Behavioral Center

Pre-Registration Packet

If you are a new client, or have not been to HBC in over a year, Please download this packet in its entirety, fill it out in as much detail as possible, and bring it with you to your next appointment.

Please arrive at least 10 minutes early so that your clinician may review the enclosed information without interfering with your session time.

Please bring your current insurance card and drivers license.

HBC is located at 2222 West Spring Creek Parkway, Suite 116, Plano 75023. We are two blocks west of Custer Parkway on the south side of the road.

We look forward to your upcoming visit.

WELCOME TO HERITAGE BEHAVIORAL CENTER

CLIENT'S NAME _____

Today's Date ____/____/____

Appointment time ____:____ am pm

Your Therapist

____ C. Jane Morrison, Ph.D., LCSW, LMFT

____ Rebecca S. Jones, Ph.D., LCSW, LMFT

____ Miles I. Morrison, MSSW, LCSW, SAP

____ Lisa Ciminelli, MSSW, LCSW

____ Karen Herbert, MSSW, LCSW

____ Mamoonah Hassan, MA, LPC

____ Sandra K. Walton, MSW, LCSW

____ Patricia Mayo, MSW, LCSW

____ Dianne Pipkin, MSSW, LCSW

____ Jean Avery, MA, LPC

____ Wayne Crooks, MSW, LCSW

____ Joyce Shephard, MA, LPC

PLEASE....

1. Complete all attached paperwork in detail.
2. Provide a copy of your drivers license and insurance card.
3. Sign all items and pages as indicated.
4. Provide authorization number from your health plan _____
5. Provide number of sessions authorized by your health plan _____
6. Your deductible \$ _____ and your copay \$ _____

THANKS.

For Office Use Only: DSM IV TR Axis I _____ GAF _____

Administrative office notes: _____

NEW PATIENT REGISTRATION

Today's Date ____ / ____ / ____

Patient's Name _____ Date of birth ____ / ____ / ____

Address _____ City _____ State ____ Zip _____

Male Female Single Married Divorced Separated Other _____

Employer _____ Occupation _____

Social Security Number ____ - ____ - ____ Email _____

Home phone _____ Okay to call? Y N To leave message? Y N

Office phone _____ Okay to call? Y N To leave message? Y N

Cell phone _____ Okay to call? Y N To leave message? Y N

HOW WERE YOU REFERRED TO OUR PRACTICE? _____

Person completing this packet _____ Rel. To patient _____

IN CASE OF EMERGENCY, CONTACT _____ at _____

Name of Insured _____ Date of birth ____ / ____ / ____

Address _____ City _____ State ____ Zip _____

Male Female Single Married Divorced Separated Other _____

Employer _____ Occupation _____

Social Security Number ____ - ____ - ____ Email _____

Relationship to patient _____

Home phone _____ Okay to call? Y N To leave message? Y N

Office phone _____ Okay to call? Y N To leave message? Y N

Cell phone _____ Okay to call? Y N To leave message? Y N

Your Clinical Information

Why are you seeking therapy today? _____

Previous counseling and hospitalizations (when, where, why) _____

Current medications and dosages _____

Previous medications _____

My current physician and phone number _____

My current psychiatrist and phone number _____

My current specialist(s) and phone numbers _____

Did you benefit from your previous therapy? (Why or why not) _____

How did you find out about Heritage Behavioral Center? _____

Is there anything else we should know about you before your first session begins? _____

Please read and initial all items on lines provided at end of each statement.

1. If you have no insurance or other health coverage, and prior arrangements have not been approved, our fee for each 45-minute session is \$130. If you are accessing your benefits, your carrier has negotiated the following fees with HBC:

Initial session rate is \$ _____ of which your copay is \$ _____. The rate for subsequent sessions is \$ _____ of which your copay is \$ _____. You are also responsible for any annual deductibles as outlined by your insurance benefits plan. Your deductible is \$ _____.

NOTE: Some information regarding your benefits has not been received by our business office. Thus some of the information above could not be itemized. (_____)

X _____

2. Responsible party for co-payments: If the patient is a child under the age of 18, the parent bringing the child to therapy is responsible for payment prior to rendering of services.

X _____

3. Cancelled appointments: If you are unable to honor your appointment, we ask that you cancel at least one business day in advance, so that another patient on our waiting list may be offered that time. If we have not been notified one business day prior, or if the appointment is not kept, you shall be billed the contracted rate (insurance plus co-pay). Your carrier will not pay for late cancels or no-shows, but in most cases, allows HBC to bill you. Employee assistance programs that do not allow HBC to bill in these instances, request that we subtract the session from your allotted number of approved sessions.

X _____

4. We will file your benefits claims for you, with payment being remitted directly to HBC. Although we make diligent efforts to collect from your carrier, you are ultimately responsible for payment. Any account balance exceeding \$250, or any amount 90 days past due is your responsibility. Additional charges for testing, court testimony, consulting and other services, are not covered by your benefit plan, and are payable in advance.

X _____

5. If your HBC clinician is not in your provider network, we will provide you a receipt for your payment so that you may file for reimbursement. It is your responsibility to know if your clinician is in network, by calling the number on your benefits card.

X _____

6. Although information disclosed in sessions is held in strict confidence according to HIPAA regulations, your carrier may require some data in order to process claims.

X _____

7. Adolescents have a right to confidentiality, which will only be waived if (s)he is in imminent danger. While substance and alcohol usage is serious in nature, and is a focus of treatment, it may not constitute imminent danger.

X _____

8. Your HBC clinician reserves the right to discontinue treatment if, in the clinician's professional opinion, appropriate progress is not being attained. Upon your request, your clinician will assist you in finding another service provider, or you may contact your benefits carrier for assistance.

X _____

9. If the patient is a child or adolescent, and divorce, separation, custody, or visitation is involved, both parents may be required to sign our standard treatment agreement, and the divorce decree must be submitted to HBC. We do not file with your benefits carrier for court-ordered services. The fee is \$150 per 45-minute session, and is payable prior to the session. In many cases, HBC may require a retainer. All time spent by the clinician is billable.

X _____

10. Sessions are 45 minutes in length. If you arrive late for the session, it will still end at the scheduled time in order to accommodate other patients. If you arrive more than 15 minutes late, the clinician reserves the right to consider the session as not kept, and may bill accordingly.

X _____

I, the undersigned patient or responsible party, understand and accept these conditions as written.

Date ____ / ____ / ____

Signature _____

Witness _____

INSURANCE AUTHORIZATION AND RELEASE

I, the undersigned, certify that I, or my dependents, have insurance or employee assistance program benefits in effect with the following carrier: _____.

I assign directly to HBC and CJM & RSJ, Inc., and/or its clinicians all related benefits in order to pay for services rendered. Further, I understand that I am financially responsible for any and all debts related to services rendered, whether or not the carrier makes payment. I authorize you to release all information necessary to secure payment. I authorize use of this signature on all claims submissions.

Date ____/____/____

Signature _____

**RELEASE of CONFIDENTIAL INFORMATION
to PRIMARY PHYSICIAN and/or SPECIALISTS**

I hereby authorize HBC and CJM & RSJ, Inc., and/or its therapists to disclose to the professionals listed below all clinical data necessary to assure continuity of care, including periodic updates and current health status. This authorization becomes effective ____/____/____, but may be revoked by me in writing at any time, except to the extent of action already taken. This authorization shall terminate six months after termination of treatment, or upon my written notice to you. I understand that I may request a copy of this release at any time in writing or in person. HIV and AIDS disclosures are not included in this release unless initialed here: _____.

Date ____/____/____

Signature _____

Print your name here _____

Name of professionals covered in this release: _____

OR

I DECLINE THIS RELEASE _____.

**Continuity of Care
Information Enclosed Regarding Your Patient
(FOR CLINICIAN USE ONLY)**

TO: _____

Fax: _____ - _____ - _____

Date ____ / ____ / ____

FROM: _____

Fax: 972-964-3044
Heritage Behavioral Center
2222 West Spring Creek Parkway
Suite 116
Plano, Texas 75023
Voice 972-964-3214
heritagecenter@earthlink.net
www.hbcplano.org

RE: Your patient _____ **DOB** ____ / ____ / _____,
was last seen in my office on ____ / ____ / _____, and has been seen _____ times to
date.

DSM IV diagnosis: **Axis I** _____ **Axis II** _____ **Axis III** _____
 Axis IV _____ **Axis V GAF** _____

Current treatment or update: _____

**Please contact me with any recommendations or information to enhance ongoing care of
this patient. Please notify me if you would like periodic updates.**

Provider signature _____

Receipt of HIPAA Information

I hereby acknowledge receipt of the PRIVACY PRACTICES notification as prescribed by HIPAA.

I understand that HIPAA places restrictions on the release of psychotherapy notes to patient or family. Further, I understand that I may request additional information by contacting the U.S. Department of Health and Human Services at 1-877-696-6775, or by writing the Privacy Officer at Heritage Behavioral Center.

Printed name _____

Signature _____

Date ____ / ____ / ____

I am the (circle one, please) Patient Parent Guardian

Other _____

Witness _____

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 IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal Program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and healthcare operations.

TREATMENT means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination.

PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

HEALTHCARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken such actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

THE RIGHT to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

THE RIGHT to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

NOTICE OF PRIVACY PRACTICES, page two

THE RIGHT to inspect and copy your protected health information.

THE RIGHT to amend your protected health information.

THE RIGHT to receive an accounting of disclosures of protected health information.

THE RIGHT to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective APRIL 14, 2003, and we are required to abide by the terms of the NOTICE OF PRIVACY PRACTICES currently in effect. We reserve the right to change the terms of our NOTICE and to make the new NOTICE provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised NOTICE from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE OF CIVIL RIGHTS, about violations of the provisions of this NOTICE or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information:

For information or to file a complaint, call or write

**The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257 1-877-696-6775**

**Or Miles I. Morrison, LCSW, DCSW, SAP
Privacy Officer for HBC
2222 West Spring Creek Parkway, Suite 116
Plano, Texas 75023
972-964-3214 Fax 972-964-3044
heritagecenter@earthlink.net**