OCONEE CENTER FOR BEHAVIORAL HEALTH

1360 Caduceus Way
Building 400, Suite 102
Watkinsville, GA 30677
706-310-6907

New Patient Information Form

Name: _____ Age: _____

Date of Birth: _____ SSN: _____ Sex: _____

Marital Status: _____ Primary Care Phys: _____

Driver's License #: _____ State: _____

If Child, Guardian's Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone #: _____

E-Mail Address: _____

Referred By: _____

Emergency Contact Name: _____

Emergency Contact #: _____ Alt. #: _____

Emergency Contact Address: _____

City: _____ State: _____ Zip Code: _____

Relationship to Patient: _____

Primary Insurance Information

Policy Holder's Name: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Ins Co. Phone #: _____

Policy #: _____ Group #: _____

Secondary Insurance Information

Policy Holder's Name: _____

Relationship to Patient: _____

Insurance Co. Name: _____ Ins Co. Phone #: _____

Policy #: _____ Group #: _____

Person Responsible For Payment, If Other Than Patient:

Name: _____ Date of Birth: _____

Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Alt. #: _____

SSN #: _____ Employer: _____

Driver's License #: _____ State: _____

Authenticity Statement and Assignment of Benefits

Section I. Authenticity: I, the undersigned, certify that I am the recipient of all treatment preformed by Oconee Behavioral Medicine, LLC. I certify that all information provided above is true and correct to best of my knowledge.

Section II. Assignment of Benefits: I, the undersigned, hereby authorize and release Oconee Center for Behavioral Health, LLC to bill my insurance and/ or Medicare on my behalf for the cost of any services received at OCBH, LLC. Further, I authorize and request my insurance company carrier to pay directly to Oconee Behavioral Health, LLC, the amount due to me under the terms of my policy, as a result of medical services rendered at OCBH, LLC. I understand that I am financially responsible for any claim denial, co-insurance, co-payment or deductible and agree to payment at the time services are rendered by OCBH, LLC. I understand that if I do not

have insurance coverage or my insurance coverage lapses I will be responsible for the full monetary amount of services rendered by OCBH, LLC.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

Consent to Treat

As a legally consenting individual, I agree to permit the Providers, Faculty, and Staff of Oconee Behavioral Health, LLC to provide treatment and therapy to myself or my child as applicable. I understand that I have the right to terminate treatment at any time.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

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Consent Form For Release/ Request of Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Legal Guardian if Patient is a Minor: _____

I, _____, give me permission to the Providers, Faculty, and Staff of Oconee Behavioral Medicine, LLC as well as the person(s) listed below to exchange information and/ or records regarding myself or my dependents. I give my permission for a faxed or photo copied signature to serve as an original regarding this release. The purpose of this release is to request/ release information for the benefit of the patient's diagnosis, treatment planning, continuity of care, family medical leave, disability requests and/or benefit claims for life/ health insurance application. The information released pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the privacy act. This authorization may be revoked by the individual signing this consent by providing a written, signed and dated, request to withdraw the authorization except to the extent that the action has already been taken.

1.Name: _____

Phone #: _____ Fax #: _____

2.Name: _____

Phone #: _____ Fax #: _____

3.Name: _____

Phone #: _____ Fax #: _____

4.Name: _____

Phone #: _____ Fax #: _____

Printed Patient Name: _____

Signature: _____

Relationship: _____ Date: _____

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HIPPA 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.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information. This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Use and Disclosure of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice and any other use required by law.

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your doctor may share your health information with a specialist, referring physician or therapist, or hospital staff that will assist in your treatment. Your protected health information may be provided to a physician or therapist to whom you have been referred or who is providing on-call coverage to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, your protected health information will be provided to the staff of Oconee Center for Behavioral Health, LLC. which manages the billing and records storing in our office. Also, for example, we may disclose information about the services provided to you to claim and obtain payment from your insurance company, managed care company, health plan, or Medicare.

Healthcare Operations: We may use or disclose as-needed, your protected health information in order to support the business activities of your physician's or therapist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of health care students, licensing, outside storage of medical records, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

Sharing Your Health Information: There are situations when we are permitted or required to disclose health information without your authorization. These situations are: when a state or federal law

mandates that certain health information be reported for a specific purpose; for public health purposes, such as contagious disease reporting, investigation or surveillance; for notices to and from the Federal Food and Drug Administration regarding drugs or medical devices; to protect victims of abuse, neglect, or domestic violence; for health oversight activities such as investigations, licensing, audits and inspections; for lawsuits, legal proceedings, and when otherwise required by law; when requested by law enforcement as required by law or court order; to report criminal activity; to report to coroners, medical examiners, and funeral directors; for inmates; for organ and tissue donation; for research approved by our review process under strict federal guidelines; to reduce or prevent a serious threat to public health and safety; for worker's compensation or other similar programs if you are injured at work; for specialized government functions such as military activity, intelligence, and national security; for incidental disclosures that are an unavoidable by-product of permitted uses or disclosures; and disclosures to "business associates" who perform health care operations for us and who commit to respect the privacy of your health information.

Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

All other uses and disclosures will be made only with your signed consent or authorization. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: You have the right to inspect and copy your protected health information. Fees may apply. Under limited circumstances, we may deny you access to a portion of your health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. These requests must be in writing. Your physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. Fees may apply. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

This notice was published and becomes effective on or before April 11, 2016. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at 706-286-8442. Signature below is only acknowledgment that you have received this Notice of our Privacy Practices:

Printed Patient Name: _____

Patient Signature: _____

Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

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Patient Right and Responsibilities

Patient Rights:

Confidentiality is a privilege protected by law and ethics of the counseling profession that allows for strict private discussion of issues that concern you. Exceptions include:

- Disclosure to appropriate authorities or family members when there is sufficient cause to believe that you pose a threat of physical harm to yourself or others.
- Additionally, it is required by law to report any form of child neglect or abuse.

Informed Consent refers to your right to an explanation of your condition and treatment that you can understand. You have a right to participate in the planning of your treatment, refuse treatment and file complaints or compliments. Treatment often involves addressing concerns that are distressing and you can discontinue at any tie, although this is best done in consultation with your provider of care.

Respect and Non-Discrimination are part of your treatment regardless.

Telephone Consultations: refer to the occasional need to consult briefly by phone. For these necessary and brief consultations, there is no charge. However, if you desire further assistance, we can either schedule an earlier office appointment or more extensive phone consultation; the fees for which are not routinely covered by insurance plans.

Patient Responsibilities:

We value our patients and the time for office visits has been reserved especially for you. We expect our patients to place the same value on our services and time. Cancellation Policy requires a 24-hour notice for canceling or rescheduling appointments. Missed appointments or late cancellations are subject to the following fees:

1st Cancelation/No Show: $65.00
2nd Cancelation/ No Show: $80.00
3rd Cancelation/ No Show: $120.00

THE OFFICE CANNOT BE HELD RESPONSIBLE FOR APPOINTMENT REMINDERS. Note that you can leave a message after business hours and on weekends at 706-286-8442. Continued failure to cancel appointments within 24-hours, appointment intervals greater than 12 weeks, or frequent rescheduling of appointments will result in termination of services. New patients who miss their first appointment without proper notification will not be allowed to reschedule.

Fee Payment is due at time of service unless other arrangements have been discussed. It is the patient's responsibility to notify the receptionist of any change in address, phone number or insurance. We appreciate the opportunity to serve your behavioral health needs. Please assist us in providing a more efficient service to you by contacting your insurance carrier to understand the extent and limitations of your benefits and to obtain required authorization. We also request that when you attend your session you be prepared to provide the co-pay and/or deductible determined by your carrier. Failure to obtain proper authorization may unfortunately result in additional charges to you.

Printed Patient Name: _____

Patient Signature: _____

Date: _____

If Signed by Legal Representative, Please Print Name and Relationship Below:

_____

Please Indicate which Provider you are requesting a New Patient Appointment:

_____ **Andrew P. Heidesch, LMFT**

_____ **Melissa Forschler, LMFT**