Adolescent Patient Information Instructions

Welcome to Premier Behavioral Health Services

Enclosed are patient information forms. Please fill out completely and bring your **Insurance Card(s)** and **Driver License** when you arrive at your appointment so that we may photocopy them.

Bring completed packet, a list of your medications, and your co-pay or deductible. This is required at the time of service or appointment will be rescheduled. We accept CASH, CHECKS, or CREDIT CARDS at this time.

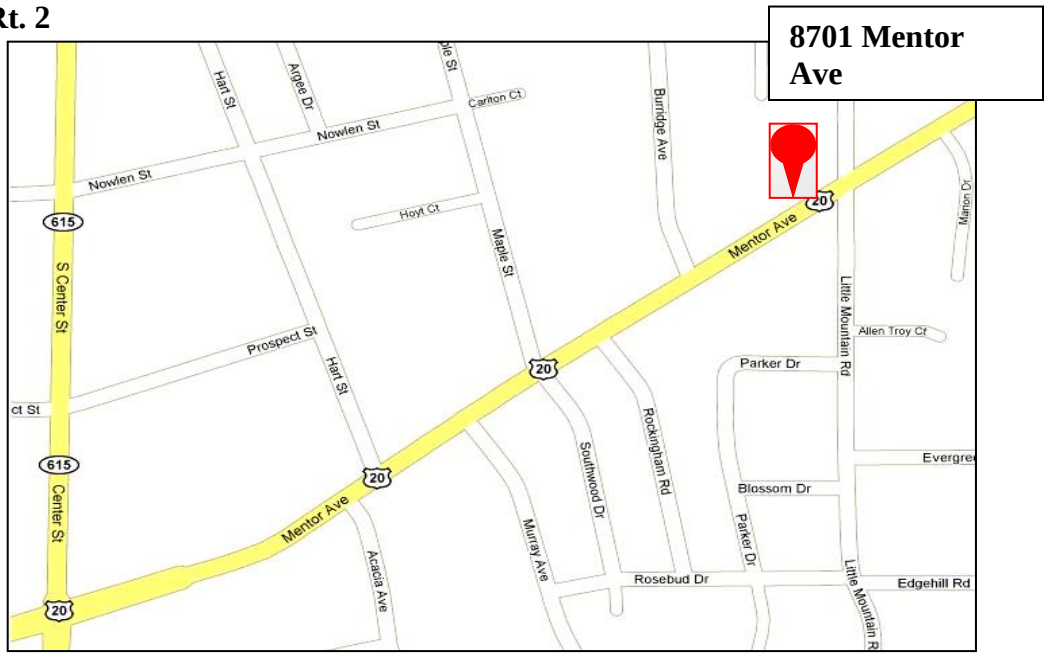
The appointment will be approximately one hour for your first visit. If appointments are not cancelled within 24 hours, you may be charged a late cancellation fee. If no notification is received, you will incur a no-show fee of $50.00. Please note, no further appointments will be scheduled until this payment has been received.

In case of a minor or an adult under guardianship, a parent or legal guardian must be present at the first appointment. PLEASE NOTE: IF FINANCIALLY RESPONSIBLE PARENT DOES NOT REGULARALY ATTEND APPOITMENTS, A CREDIT CARD MUST BE KEPT ON FILE. AUTHORZATION FORM CAN BE FOUND IN PACKET.
If you are not a biological parent, you must bring in proof of guardianship. **Please do not bring other children with you to this appointment. Children cannot be left unattended.**

Directions to our office

Our office is **east** of 615 on Mentor Avenue. We are on the north side of the street and are located next to Citizens Bank. The office is a brick building and the **entrance driveway** is situated in between our office building and Citizens Bank. **Please note that our entrance door and parking lot are in the rear.**

Rt. 2



Rt.90

For your first appointment, please arrive 10-15 minutes prior in order to check-in without disrupting your scheduled time.

PREMIER BEHAVIORAL HEALTH SERVICES
Adolescent Personal and Family History

PATIENT INFORMATION Date: _____

Child's Name: _____ ☐ Male ☐ Female

Date of Birth: ___/___/_____ Age: _____ Social Security #: _____-___-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____

Form Completed By: _____

Relationship to Minor: _____

Financially Responsible Parent to Minor: _____

Address (if different from above):_____ Phone: (____)_____

PLEASE NOTE: IF FINANCIALLY RESPONSIBLE PARENT DOES NOT REGULARALY ATTEND APPOITMENTS, A CREDIT CARD MUST BE KEPT ON FILE. AUTHORZATION FORM CAN BE FOUND IN PACKET.

Where does your child attend school _____

Child's Primary Care Physician_____Phone:_____

Past Illness/Allergies _____

_____

_____

INSURANCE INFORMATION **(MUST BE FILLED OUT COMPLETELY)**

Primary Insurance: _____

Primary Cardholder Name: _____

DOB: ____/_____/_____ Social Security #: _____-____-_____

Patient's Relationship to Primary Cardholder: _____

Insurance ID#: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

Secondary Insurance: _____

Primary Cardholder Name: _____

DOB: ____/____/_____ Social Security #: _____-____-_____

Patient's Relationship to Primary Cardholder: _____

Insurance ID#: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

What is the primary reason for seeking treatment for your child? _____

_____

_____

_____

_____

What concern(s) is your child currently experiencing that should be addressed as part of therapy?

_____

_____

_____

_____

MENTAL HEALTH HISTORY

If applicable, please describe your child's previous mental health treatment:

When	Where	Name of Mental Health Professional	Purpose of Treatment	Results	Reason for Terminating Treatment

Is your child currently seeing any other clinician for the above? ☐ Yes ☐ No

If yes, name of provider: _____ Phone: (____) _____

FAMILY RELATIONSHIPS AND SOCIAL HISTORY

Mother's Name: _____ Age: _____ ☐ Birth ☐ Adoptive

Legal Guardian of Child? ☐ Yes ☐ No Lives With Child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed

Name of Spouse/Partner: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Occupation: _____ Place of Employment: _____

Father's Name: _____ Age: _____ ☐ Birth ☐ Adoptive

Legal Guardian of Child? ☐ Yes ☐ No Lives With Child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed

Name of Spouse/Partner: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____ Cell Phone: (_____) _____ Work Phone: (_____) _____

Occupation: _____ Place of Employment: _____

Year Parents Married? _____

Year of Divorce or Separation (if applicable)? _____

What are the current custody/visitation arrangements (if applicable)?

_____

_____

_____

NOTE: Documentation of custody or legal guardianship may also be required.

Do you have significant concerns about your child's relationship with a family member?

☐ No ☐ Yes (please explain): _____

_____

Is your child adopted? ☐ No ☐ Yes

If yes, what year? _____

ADDITIONAL INFORMATION

Please feel free to list any additional information that may be helpful for your child's therapy:

_____

_____

_____

_____

_____

MEDICATION LIST

Name of Medication	Dosage	Prescriber

_____ _____

Parent/Guardian Signature Date

Premier Behavioral Health Services
8701 Mentor Avenue
Mentor, OH 44060
Phone: 440-266-0770
Fax: 440-266-0257

ADOLESCENT CONSENT FOR TREATMENT

Patient Name: _____ **D.O.B.** _____

Facility: ____PREMIER BEHAVIORAL HEALTH SERVICES_____ **Soc. Sec. No.** _____

The purpose of these services are to provide assessment, plan of care, monitor patients' needs and to improve quality of life for patients.

I give my consent for clinicians of Premier Behavioral Health Services to provide psychiatric consultation and treatment as needed.

Premier Behavioral Health Services is a private multi-disciplinary practice. An Advanced Practice Nurse may also provide an assessment and plan of care, if applicable. It is the policy of this practice to not solely allow medication management unless indicated by a PBHS professional.

Our communication will be confidential and only relevant information will be shared with clinical members of each individualized treatment team. Information will be exchanged between my Psychologist, Counselor, Advanced Practice Nurse, and/or Psychiatrist.

Confidential information may be disclosed if it is necessary for protection from immediate harm.

I authorize any holder of medical or other information about me, including Premier Behavioral Health Services, to release to the Social Security Administration, Health Care Financing Administration or its intermediaries, carriers or state fiscal agents any information need for this or related Medicare/Medicaid claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare/Medicaid assignment of benefit apply.

Patient Name (Please Print) _____

Patient Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

Adolescent Consent for Communication

This consent must be signed in order for any associate of Premier Behavioral Health Services to communicate or discuss protected health information about the patient with a caretaker or family member. This includes information related to the care or changes to the care a patient has received.

I, *(patient name)* _____, consent to all associates of Premier Behavioral Health Services, which may include the attending Psychologist, Counselor, Advanced Practice Nurse, and/or Psychiatrist, to discuss healthcare information about my care to the following people.

Please list any person that Premier Behavioral Health Services may disclose information to:
PLEASE NOTE: REGARDLESS OF PARENTAL PREFERENCE, IF BOTH PARENTS SHARE CUSTODY OF CHILD, BOTH PARENTS MUST BE INCLUDED UNDER CONSENT FOR COMMUNICATION.

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Additional Comments: _____
_____

_____

_____

_____

_____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Premier Behavioral Health Services
Adolescent Patient Privacy and Contact Information

Patient Name: _____ Birth Date: ____/___/_____

Parent/Guardian Name: _____

How may we contact you?

1. Primary phone number: (_____) _____ Contact Name: _____
   May we leave a message? □ Yes □ No

2. Secondary phone number: (_____) _____ Contact Name: _____
   May we leave a message? □ Yes □ No

Please sign below indicating you have received and reviewed the PBHS Privacy Policy (found on the last page of this packet):

_____ _____ _____ _____
Parent/Guardian Date Child Date

PREMIER BEHAVIORAL HEALTH SERVICES FINANCIAL POLICY

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies. A therapeutic relationship is built on trust and respect. As such, every effort will be made to be on time for your scheduled appointment; we ask that you give the same courtesy if you are unable to keep your appointment. Please read, sign, and date the financial policy below.

1) Payment is due at the time of service.

2) Per PBHS policy, if the financially responsible parent is not actively attending appointments, we require a credit card be kept on file. Please fill out payment authorization form located in packet.

3) Keep in mind that your insurance policy is a contract between you and your insurance company. We will file your insurance claim in a timely manner. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. Any balance held over 90 days will be sent to a collection agency and could result in a negative mark on your credit rating

4) We do our best to maximize your insurance benefits when filing your claims. However, payment for services, and knowing what is covered, is always the responsibility of the policy holder.

5) Cancellation/ No Show Policy for Appointment
   We understand you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, a situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
   If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty dollar ($30) late cancel fee; this will not be covered by your insurance company. If you provide no notice, you will incur a fifty dollar ($50) no-show fee. You may not reschedule your appointment without payment of this fee.

6) Cancellation/ No Show Policy for Neuropsychological Assessments
   Due to the large block of time needed for neuropsychological assessments, last minute cancellations can cause problems and added expenses for the office.
   If a neuropsychological assessment is not cancelled at least 48 hours in advance you will be charged a hundred and twenty five dollar ($125) fee; this is will not be covered by your insurance company. You may not reschedule your appointment without payment of this fee.

_____ _____ ____/____/____

Print Name Patient/Guardian Signature Date

Patient Account #_____ (Office Use Only)

PBHS
PREMIER BEHAVIORAL HEALTH SERVICES

8701 Mentor Avenue
Mentor, Ohio 44060
440-266-0770

Payment Authorization Form

Schedule your payment to be automatically charged to your Debit, Visa, MasterCard, American Express or Discover Card.

Please complete the information below:

Patient name: _____ **Chart ID #**_____
(Internal Use)

I, _____, **authorize Premier Behavioral Health**
(Name on card)
to charge my credit card for payment of services provided.

Billing Address _____ Phone# _____

City, State, Zip _____ Email _____

Credit Card

☐ Visa ☐ MasterCard
☐ Amex ☐ Discover

Cardholder Name _____

Account Number _____

Exp. Date _____ Code _____

Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing. I agree to notify **PBHS** in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I certify that I am an authorized user of this credit card account and will not dispute these scheduled transactions with my credit card company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

NOTICE OF PRIVACY POLICIES FOR PREMIER BEHAVIORAL HEALTH SERVICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. ***PLEASE REVIEW CAREFULLY AND RETAIN FOR YOUR RECORDS.***

Introduction
At Premier Behavioral Health Services, Inc. we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information
Each time you visit, Premier Behavioral Health Services, Inc., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others

Your Health Information Rights
Although your health record is the physical property of Premier Behavioral Health Services, Inc., the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities
Premier Behavioral Health Services, Inc. is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If have questions and would like additional information, you may contact the practice's Privacy Officer, Premier Behavioral Health Services at 440-266-0770.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:
Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201

Examples of Disclosures for Treatment, Payment and Health Operations
We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.