ASTRA BEHAVIORAL HEALTH LLC

CHILD/ADOLESCENT PATIENT INFORMATION

Name:_____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ M _____ F Age: _____ SSN: _____

School: _____ Grade:_____

Who referred you to our office: _____

PARENTS INFORMATION

Mothers Name:_____ DOB:_____

SSN: _____Cell Phone: _____ Home Phone: _____

Employer: _____ Email Address:_____

Fathers Name:_____ DOB:_____

SSN: _____Cell Phone: _____ Home Phone: _____

Employer: _____ Email Address:_____

Step-Mothers/Step-Father Name:_____

Preferred method of appointment reminder (circle one) TEXT EMAIL

Best Cell Number for reminder text: _____ Best Email: _____

INSURANCE INFORMATION

DO YOU HAVE MORE THAN ONE INSURANCE? YES NO

Primary Insurance Company: _____ Phone: _____

ID/ Policy #: _____ Group # : _____

Subscriber's name: _____ DOB: _____ SSN: _____

SECONDARY INSURANCE:

Insurance Company: _____ Phone: _____

ID/ Policy #: _____ Group # : _____

Subscriber's name: _____ DOB: _____ SSN: _____

Parents Signature: _____Date: _____

ASTRA BEHAVIORAL HEALTH

AUTHORIZATION FOR OUTPATIENT TREATMENT

PATIENT NAME: _____

The undersigned has been informed of the treatment necessary and that the treatment and procedures will be performed by psychiatrist and / or therapist or assisted by other staff members of Astra Behavioral Health LLC. Authorization is hereby granted for such procedures and treatment.

Patient/Parent Signature: _____ **Date:** _____

FEE AGREEMENT

I certify the information given by me is correct and accept full responsibility for all charges incurred. If you have insurance that you want us to bill for services, we are glad to bill this company with your consent below. I authorize Astra Behavioral Health LLC to furnish information from my medical record to my insurer. I hereby assign and authorize payment directly to Astra Behavioral Health for all charges incurred by me for treatment and services.

Charges for services are based on the usual, customary and reasonable fee for the area. All payments are required at the time of service. I agree to pay any self –pay, deductible and or co-insurance (if applicable) at the time of each visit.

I understand that in the event that my insurance company does not pay for my services I am responsible for the total fee within 30 days from denial. I understand that I am responsible for any balance after the insurance payments have been maid including all charges incurred in collecting these amounts if the account becomes delinquent such as court cost, collections agency commission or charges and or attorney fees. **For Medicare Patients:** I certify that the information provided by me in applying for payment under title XV of social security act is correct. I authorize Astra behavioral Health LLC to release to the social security administration or its carriers and medical information from my record to assist in the processing of my insurance claims for services received. I request that payment be made directly to the above named facility.

Patient/Parent Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF VIDEO MONITORING PROCEDURES:

Astra Behavioral Health LLC utilizes a video camera as a necessary precaution to treatment. In order to promote the safety of all patients and staff, there may be times when the patient is being monitored by camera. Please note the bathroom areas are not monitored. By signing below, I understand that I am aware of video monitoring procedures.

Patient Signature: _____ Date: _____

ASTRA BEHAVIORAL HEALTH LLC

CONFIDENTIALY OF PATIENT RECORDS

Confidentiality of your records maintained by this office is protected by Federal Law and Regulations. Generally, we may not say to a person outside this facility that you are a client here unless:

1. You consent in writing
2. You present a danger to yourself or others
3. Disclosure is required by court order or subpoenas
4. Your treatment is ordered by or under court supervision
5. There is suspected physical or sexual abuse or neglect of a child or adult.
6. Disclosure is made to medical personal in a medical emergency or to a qualified personnel for audit or program evaluation
7. Your insurance must verify treatment before paying our charges.

(See 42 U.S.C. 290dd-3 and 42 U.S.C. 290ee-3 for Federal Laws and 42 CFR Part 2 for Federal Regulations)

I attest that the office staff has discussed and questions or concerns I may have regarding the confidentiality of my records.

Patient / Parent Signature: _____ **Date:** _____

PATIENT RESPONSIBILITIES b

Patients of Astra Behavioral Health LLC assume certain responsibilities.

1. The patient is responsible for providing information about their health, past illness, hospital stays. And all use of medication. They are responsible for asking questions when they do not understand information or instruction provided. If they feel they cannot follow through with treatment, they are responsible for informing their provider.
2. Your health depends not only on care provided by this facility but also on the decisions he/she makes in their daily life. The patient is responsible for recognizing the effects of their lifestyle on their health.
3. The patient and anyone with them in our facility are responsible for being considerate of the needs of other patients and staff members.
4. The patient is responsible for providing current and correct insurance information and for working with us for payment of services received.
5. **Patient is responsible for giving a minimum of 24 hour notice when unable to keep an appointment: failure to provide said notice shall result in a $25.00 fee. When a patient has booked standing appointments and failed to keep said appointment two times in a row the patient shall no longer be allowed to book standing appointments with providers at this office.**

I have read and received all explanations of my rights to privacy and responsibilities as a patient of Astra Behavioral Health LLC and acknowledge such by my signature.

Patient/ Parent Signature: _____ **Date:** _____

ASTRA BEHAVIORAL HEALTH LLC

Medical History Summary

PATIENT NAME: _____ DATE: _____

Individuals sometimes receive services on an ongoing basis and from more than on provider. To promote continuity of care, both over time and among providers this facility maintains a record for anyone seen. PLEASE ANSWER ALL QUESTIONS BELOW:

Family Physician name: _____ Phone: _____

Pharmacy Name: _____ Phone:_____

Is patient current on immunizations? Yes _____ No _____

I am/have been treated for the following:

Diagnosis: _____ date diagnosed: _____

Diagnosis: _____ date diagnosed: _____

Diagnosis: _____ date diagnosed: _____

List of operations or hospitalizations:

_____ Date: _____

_____ Date: _____

List all medications being taken and prescribing physician:

Medication: _____ Physician: _____

Medication: _____ Physician: _____

Medication: _____ Physician: _____

Medication: _____ Physician: _____

I am allergic to: _____

Patient /Parent Signature: _____ Date: _____

Cancellation/ No show Policy for Psychiatric and Medication Management Appointments

Our goal is to provide quality individualized medical care in a timely manner. No- shows, late arrivals and cancellations inconvenience those individuals who need access to care. We would like to remind you of our policy regarding missed appointments.

A "no show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance. A "late arrival" is arriving for your appointment past scheduled appointment time.

Cancellation/ No Show Policy for Appointments

In order to be respectful of the medical needs of other patients, please be courteous and call our office promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care. We understand that there are times when you must miss your 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.

Please cancel at least 24 hours in advance. Patients who No- Show or late cancel two (2) or more appointments in a 6 month period, may be discharged from the practice and thus they will be denied any future appointments

Late Arrival Policy

We understand that delays can happen. That said, we must try to keep the other patients and providers on time.

If you arrive 15 minutes past your scheduled time, we will have to put you in when an appointment arises, accommodate you at the end of the day, or reschedule your appointment.

Cancellation/ No Show Policy for Psychiatric Evaluations

Due to the large block of time needed for initial evaluations, last minute cancellations cause problems that create a negative financial impact on our agency.

Please cancel at least 24 hours in advance. If you cancel outside of the 24 hour time frame or no show, we will not be able to schedule another appointment for you. If you fail to confirm your appointment 24 hours in advance you will forfeit your appointment time and we may fill your time slot with another patient.

_____ _____ _____

Print Patient Name Signature Patient/ Guardian Date

Provider Signature: _____ Date: _____

Welcome to Astra Behavioral Health

At Astra Behavioral Health, we are committed to providing the best resources to meet all your mental health needs. We understand that there are often extra challenges, and we are here to help. To get started, please circle Yes or No to the following questions.

Client Name: _____

1. Are you in need of resources such as housing, clothing, employment, education, food or more? Y N
2. Do you have transportation issues? Y N
3. Do you need assistance with benefits such as food stamps, SSI, SSDI, KTAP or insurance? Y N
4. Would you like help finding community activities for yourself or your family? Y N
5. Have you experienced alcohol or drug problems within the past year? Y N
6. Are you having trouble accessing medical care? Y N
7. Are you getting overwhelmed? Y N

We can provide strength, hope, resources, and skills in these areas through Targeted Case Management, Supported Employment, or Peer Support Services. If you answered yes to any of these questions, we will contact you to assist in getting the help you need.

Thank you,

The Astra Behavioral Health Team

Authorization for Behavioral Health and Primary Care Physician to Share Confidential Information

Member Consent to Release Confidential Information

I, _____ give permission to Astra Behavioral Health,
(Patient Name)
LLC and my Primary Care Physician_____ office phone number _____to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, NOT including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care.

This consent form expires 1 (one) year from the date of signing and I can choose to cancel it at any time.

_____ _____
Member/Guardian/Authorized Representative *Date*

_____ _____
Witness *Date*

Member Refusal to Release Confidential Information

I, _____ **DO NOT** give permission to Astra Behavioral Health LLC and my Primary Care Physician _____ to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, including the results of a blood test for antibodies to the human immunodeficiency virus (HIV). I understand the purpose of sharing information is to help me receive better care. I also understand that my refusal to share information does not affect my insurance coverage.

_____ _____
Member/Guardian/Authorized Representative *Date*

This consent form expires 1 (one) year from the date of signing and can be canceled at any time.

ASTRA BEHAVIORAL HEALTH LLC

AUTHORIZATION TO RELEASE/ OBTAIN PROTECTED HEALTH INFORMATION

WITH OTHER BEHAVIORAL HEALTH PROVIDERS

PATIENT NAME: _____

SOCIAL SECURITY NUMBER: _____ DATE OF BIRTH: _____

TO/ FROM: Astra Behavioral Health LLC

151 Drexler Circle Suite 1

Elizabethtown KY 42701

Phone: 270-506-2730

Fax: 270-900-0704

TO/ FROM: _____

_____

_____

_____

_____

TYPE OF PATIENT IDENTIFIABLE HEALTH INFORMATION REQUESTED

X- Initial Evaluation- Psychiatrist

X- Initial Evaluations- Therapist

X- Medication Sheet

X- Discharge Summary

X- Verbal Communication

I hereby authorize the release of my protected health information indicated to the individual/ organization listed and understand that "minimum necessary" rule will apply. I understand that my signature on this form will not affect my condition for treatment, payment, enrollment or eligibility pertaining to benefits.

PURPOSE OF RELEASE

X- Continuity of Care

I understand that I can revoke my authorization in writing at any time with the exception that the revocation will not apply to information already released in response to this authorization. If not previously revoked this authorization will expire 1 year from date release was signed.

PROHIBITION ON DISCLOSURE

This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent or the person whom it pertains, or as otherwise permitted by regulations. A general authorization for the release of medical information is NOT SUFFICIENT for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

_____ _____

Signature of Patient or Patient Representative Date

_____ _____

Relationship to Patient (if representative) Witness Signature

RECEIPT OF NOTICE OF PRIVACY PRACTICES VERSION 10403

(HIPAA FORM)

- O Over 18 years of age
- O Under 18 years of age
- O Over 18 but still dependent
- O Emancipated minor child

ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices

_____ _____

Patient's Signature Date

_____ _____

Patient's authorized representative Signature Relationship to Patient

_____ _____

Witness Signature Date

Patient indicated exceptions to the use or disclosure of his/her protected health information.

The requested exceptions are as follows:

(Please list person/persons that may access your information. Underneath their name circle which specific items they may do for you)

1._____

Make/cancel/attend/ bring to appointments pick-up prescriptions talk to doctor /therapist

2._____

Make/cancel/attend/ bring to appointments pick-up prescriptions talk to doctor /therapist

3._____

Make/cancel/attend/ bring to appointments pick-up prescriptions talk to doctor /therapist

4._____

Make/cancel/attend/ bring to appointments pick-up prescriptions talk to doctor /therapist