BRIGHTON FAMILY CENTER, PLC

NON-CONFIDENTIAL PATIENT INFORMATION

GENERAL INFORMATION

Date: _____

Patient Name: _____ Gender (*circle one*): MALE FEMALE

Date of Birth: _____ Age: _____ Marital Status (*circle one*): SINGLE MARRIED WIDOWED DIVORCED

FULL Address: _____
street city state zip

Phone: (____) _____ (____) _____ Social Sec#: _____ Driver Lic# _____
home cell

Employer/School: _____
NAME ADDRESS: street city state zip

Employer/School: _____ (____) _____ _____
Occupation Work Phone and Extension # of Years Employed

E-Mail: _____ Who Referred You: _____

Emergency Contact (name, phone, relationship): _____

With what issues would you like help, and when did they begin: _____

_____

CURRENT MEDICAL CONDITIONS

Condition/Illness	Medications & Dosage	Doctor

Family Physician: _____ Phone: (____) _____

May we discuss these issues with these clinicians. (**INITIAL** *one*): _____ **YES** _____ **NO**

Have you ever been treated by a mental health provider? (*circle one*): **YES** **NO** If yes, name of provider, phone number, treatment dates:

_____

OTHER MEMBERS OF YOUR HOUSEHOLD

Name	Relationship	Age	Name	Relationship	Age

INSURANCE INFORMATION: (please also provide copies of **FRONT AND BACK** of insurance cards)

PRIMARY INSURANCE CO.: _____ **SECONDARY INSURANCE CO.:** _____

Address of Ins.: _____ Address of Ins.: _____

Phone: (____) _____ Phone: (____) _____

Is Preauthorization needed? Yes No Is Preauthorization needed? Yes No

Authorization Number: _____ Authorization Number: _____

Circle Patient's Relationship to Insured: **Self Spouse Child Other** **Circle** Patient's Relationship to Insured: **Self Spouse Child**

Name of Insured: _____ Name of Insured: _____

Insured's Employer _____ Insured's Employer _____

Date of Birth of Insured: _____ Date of Birth of Insured: _____

ID#: _____ ID#: _____

Group#: _____ Group#: _____

ASSIGNMENT OF BENEFITS: I hereby authorize and direct my insurance/managed care company to make payment directly to my provider for services rendered. I authorize my provider to provide information to the payer for purposes of obtaining reimbursement.

SIGNATURE: _____ Date: _____

if different from above: FULL Address: _____

BILLING AND PAYMENTS

Brighton Family Center, PLC. is able to provide the service of billing insurance companies, work EAPs, or other third party payers as a courtesy to our patients. However, **PAYMENT FOR SERVICES RENDERED IS ULTIMATELY YOUR RESPONSIBILITY**. This includes providing accurate and current information to us pertaining to your coverage, as well as obtaining initial authorization for treatment and authorizations for ongoing treatment as required by your third party payer. In the event that your third party payer fails to provide payment within 30 days of submission of charges, as mandated by state law, the monies owed to Brighton Family Center, PLC. are your responsibility.

PERSON LEGALLY RESPONSIBLE FOR PAYMENT OF THIS ACCOUNT:

Name: _____ email: _____

FULL Address: _____
street city state zip

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

I AGREE TO ACCEPT FULL RESPONSIBILITY FOR ALL CHARGES INCURRED.

Signed: _____ Date: _____

SCHEDULED APPOINTMENTS: .....

- Cancellation of appointments, for any reason, **with less than a 24 business hour notice** will result in a charge of $50.00, which is due from the patient/person legally responsible for payment. Insurance does not normally cover this fee.
- Two cancelled or failed appointments may be grounds for termination of services.

FEES: .....

PAYMENT (INCLUDING COPAYMENT) IS EXPECTED AT TIME OF SERVICE:

Methods of payment include: CASH, CHECK, or CHARGE CARDS

If charge card is your preferred method of payment, you may provide your information here, which will indicate your agreement to have copays charged to your card after each session.

Circle type of card: **MasterCard** **VISA** **AMEX** **DISCOVER**

Name on card: _____

Card Number: _____

Expiration Date: _____ Security # on back of card: _____

Address Bill Received: _____
street city state zip

- An additional $25.00 charge will be assessed for checks returned unpaid for any reason.
- Cash, co-pays, and/or deductible monies outstanding for more than 60 days will be charged an interest rate of 12% per annum until paid.
- Additional fees ($35.00 per 15 minutes) will be charged for the following services: Letters, reports, completion of forms, telephone calls, emails, review of records, or other activities occurring beyond the scheduled session times. These fees are not covered by insurance, are your responsibility, and are payable at the time of service.
- Failure to pay fees in a timely manner may result in your account being turned over to a collection agency, and negative entries may appear on credit reports (e.g. TRW). Should your account need to go to collections, a fee of $100.00 will be added to the balance owed toward covering collection costs, and for which you are responsible.

Patient Signature: _____ Date: _____

Responsible Party Signature: _____ Date: _____

I HAVE READ AND UNDERSTAND THE FOLLOWING ..... _____**INITIALS**

CONFIDENTIALITY

In accordance with the law and professional ethics, patients and psychotherapists enjoy the privilege of confidentiality. The following exceptions exist, however, at which time this privilege may be waived or may not apply:

- Danger to self, others or gravely disabled;
- Child or elder abuse;
- Threat by patient or family members to harm an identifiable victim;
- Custodial parents or legal guardians have access to information pertaining to the treatment of minors;
- Involvement in legal action with allegations of psychological injury;
- Some EAP or managed care contracts require reporting behavior which may put the employee or their co-workers at risk;
- If services are provided by a non-licensed clinician, clinical information will be shared with the clinical supervisor;
- Conversations/emails via computers or mobile telephones may be subject to eavesdropping and may not be confidential;
- Third party payers and billing/collection organizations will be advised of all information needed (including personal, clinical, and administrative) for purposes of billing and collections.

CONFIDENTIALITY OF PERSONAL AND HEALTH INFORMATION (PHI)

- 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.
- Brighton Family Center, PLC is committed to protecting the personal and health information (PHI) of our patients in each of the settings in which such information is received or disclosed.
- When you complete an application for health coverage, your signature authorizes your health plan to collect personal information that includes both your medical information and individually identifiable information about you such as your social security number, date of birth, address, telephone number, etc. As a patient of Brighton Family Center,PLC, this general consent allows Brighton Family Center, PLC to communicate with your authorized providers and health plan about treatment and payment decisions.
- Brighton Family Center, PLC also participates in quality measurement activities that may require us to access your PHI, and we have policies to protect this information from inappropriate disclosure. We release this information only if aggregated or encoded.
- We will not disclose, sell, or otherwise use your PHI unless permitted by law for protection of personal safety and to the extent necessary to administer your benefit.
- We will obtain written authorization from you to use your PHI for any other purpose than indicated above.
- For any of our patients unable to give consent, we have a policy in place to protect your rights and which permits your legally authorized representative to give consent on your behalf.
- Brighton Family Center, PLC will also not release your PHI to your employer without your specific authorization, unless law permits.
- Brighton Family Center, PLC has policies in place to allow you to inspect your medical records and, when needed, to include a written statement from you. You also have the right to request an accounting of disclosures of PHI made for purposes other than those stated above. To exercise any of these rights, you may contact your provider.
- If at any time you have a complaint regarding how your PHI was used and/or disclosed, you may contact your provider and file a grievance, which will be investigated and the outcome reported in writing.
- For more detailed information regarding Brighton Family Center, PLC Confidentiality Policy, you may call (810) 229-0844 and ask to speak with Dr. Armstrong.

Signature of Patient/Guardian: _____ *Date:* _____

Print name: _____ ____ *Requested & received copy of this notice*

____ *Declined copy of this notice*