New Patient Information

Last Name_____First_____Middle_____Sex: M F

Date of Birth_____ SS#:_____Marital Status: S M D W Partner

Mailing Address: _____ Apt: _____

City: _____ State: _____Zip: _____Email:_____

Home Phone: _____ Cell Phone: _____Employed: Y N

Emergency Contact Name: _____ Relationship: _____

Address:_____City:_____State_____Zip_____

Day Phone_____Evening Phone_____

Nearest Relative: _____ Relationship: _____

Address: _____City:_____State:_____Zip:_____

Employer's Name: _____ Employer's Number: _____

Employer's Address: _____City_____State_____ Zip_____

If Patient is a Dependant or has a guardian, Please respond to this section:

Parent/Guardian: _____

Day Phone: _____Evening Phone: _____

PLEASE NOTE: Adult patients or guardians requesting treatment are responsible for all fees. If client is married or has a partner, Please fill out this section.

Spouses or Partner Name: _____

Spouse's/ Partners Address (if Different than Patients):_____

Apt: _____City:_____State:_____Zip:_____

Day Phone:_____Evening Phone_____

Spouse's/ Partner's Employer_____

City_____State:_____Zip:_____Phone:_____

PLEASE COMPLETE THE OTHER SIDE OF THIS FORM

Is the condition related to Employment: Y N Date of Injury:_____

Referred By: _____

Primary Insurance Information:

Name of Insurance Company: _____ Policy Holder: _____

Member ID or Policy#:_____ Group#:_____

Social Security# of Policy Holder:_____Sex: M F Date of Birth: _____

Address of Policy Holder: _____

City_____State_____Zip:_____

Day Phone: _____Evening Phone_____

Patients Relationship to Responsible Party and/or Policy Holder:

Self: Y N Spouse: Y N Child/Dependent: Y N Other_____

Secondary Insurance Information:

Name of Insurance Company: _____ Policy Holder: _____

Member ID or Policy#:_____Group#:_____

Social Security# of Policy Holder:_____Sex: M F Date of Birth: _____

Address of Policy Holder: _____

City_____State_____Zip:_____

Day Phone: _____Evening Phone_____

Patients Relationship to Responsible Party and/or Policy Holder:

Self: Y N Spouse: Y N Child/Dependent: Y N Other_____

Responsibility Statements

Without signature, the patient cannot be seen.

I, the undersigned, do hereby acknowledge and accept financial responsibility for the payment of all charges for service rendered to the patient listed above. I authorize AIM Behavioral Health Specialists and their agent to release any information to the insurance company to process claims. I authorize AIM Behavioral Health Specialists billing agent to bill my insurance and to send benefits directly to AIM Behavioral Health Specialists. I am responsible for any services not covered by insurance which are listed in the payment contract. All unpaid balances are subject to interest and late fee charges. I further agree to any fees associated with collection procedures.

Signed: _____ Date: _____

Authorization for Emergency Treatment

In the event of a medical emergency, I authorize AIM Behavioral Health Specialist and/or their agents to seek emergency treatment.

Signed: _____ 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 & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, new rights to understand and control how your personal 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 personal health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment for services and health care operations

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Example: We may need to share information with other health care providers involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. Example: We may disclose treatment information to insurance companies when obtaining an authorization or referral.
- **Health Care Operations** include the business aspects of running our practice. Example: Patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose your health information to a family member, friend, personal representative or other individual to the extent necessary to help with your healht care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgement in disclosing the minimum protected health information necessary to provide needed care. Your protected health information may be disclosed for public health oversighte activities, judicial or administrative proceedings, in response to pubpoena or court order, to military authorities of Armed Forces personnel, to federal officials, correctional institutions or law enforcement officials. We will report suspected abuse, neglect and/or domestic violence to the proper agencies and/or authorities. Any other uses and disclosures will be made only with your written authorization. Such authorization expires 90 days from date of consent unless noted on original authorization. You may revoke such authorization at any time in writing.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of your personal health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. If we do agree to such restrictions, we must abide by it unless you agree in writing to remove it. We are, however, not required to agree to a requested restriction.
- The right to access, inspect and copy your personal health information, with limited exceptions. This request must be submitted in writing with 10 days notice. A reasonable fee may be assessed.
- The right to request an amendment to your personal health information. We may deny your request in certain situations.
- 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 personal health information.

This notice is effective March 3, 2003. 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 Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated.

For more information about our Privacy Practices:

AIM Behavioral Health Specialists
9116 Gravelly Lake Dr SW, Suite 107
Lakewood, WA 98499
Ph #: 253-581-6106

For more information about HIPAA:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

Signature: _____ Date: _____

Payment Contract

The patient, or responsible parties, is responsible for all fees assessed for services provided by AIM Behavioral Health Specialists. Billing insurance companies is a service provided. The patient may choose to receive a statement from AIM Behavioral Health Specialists and submit his/her own claims. The patient will be held responsible for seeking referral and preauthorizations that may be required by his/her insurance company.

Services for which the patient or responsible party will be billed include but are not limited to:

- Photocopies
- Faxes, including urgent/emergency prescription refills
- Prescription authorizations
- Consultations (by phone, email or with other providers or persons) as directed by the patient
- Letters, FMLA forms, Disability forms, reports and the like
- Retrieving and forwarding copies of medical records whether by mail or fax
- Any services occurring outside the venue of the office visit

Office visits are important. We make every effort to keep office visits. Please read and sign the cancellation policy.

Patients need to be seen every three months to maintain an active patient status.

Unpaid balances are subject to interest charges, late fees and billing fees. The patient, or the responsible party, will be held accountable to pay any and all costs related to any collections procedures. If AIM Behavioral Health Specialists' should be required out of the office, deposed or otherwise consulted in regards to any dispute or collection procedures, the patient will also be held accountable.
Services may cease immediately if there is a balance more than 30 days past due.

Responsible parties will be held accountable for the funds owing on the patient's account even though the patient may be 18 years or older, especially if the responsible party facilitated any office visits.

Please read and sign the cancellation policy. Prepayment may be expected as well. Only cash or credit cards will be accepted unless the patient is well established and has received permission to pay by check. As office expenses rise and that rate of reimbursement falls, strict adherence to these policies are necessary.

We appreciate your understanding.

Patient or Responsible Party _____ Date _____

Cancellation Policy
AIM Behavioral Health Specialists

Cancellations must be made according to the following schedule, no exceptions:

- Monday appointments must be canceled on the previous Wednesday by 9:00am
- Tuesday appointments must be canceled on the previous Thursday by 9:00am
- Wednesday appointments must be canceled on the previous Monday by 9:00am
- Thursday appointments must be canceled on the previous Tuesday by 9:00am

Very rarely, the office may be open on a Friday. In the event Friday is a full work day, Friday appointments must be canceled before the preceding Wednesday by 9:00am.

You may be held responsible for your appointment time regardless of the reason for canceling the appointment.

_____ _____

Patient or Responsible Party Date

Cancellation Policy
A Renewed You

Cancellations must be made according to the following schedule, no exceptions:

- Monday appointments must be canceled on the previous Monday by 9:00am
- Tuesday appointments must be canceled on the previous Tuesday by 9:00am
- Wednesday appointments must be canceled on the previous Wednesday by 9:00am
- Thursday appointments must be canceled on the previous Thursday by 9:00am

On the rare event that Friday appointments are scheduled, as we are usually not in the office on Fridays, Friday appointments must be canceled before the preceding Thursday by 9:00am.

You will be held responsible for the charges when canceling late without any exception.

All appointments have to be prepaid 8 (eight) days prior to the appointment by cash or credit card. Personal checks will not be accepted unless previous arrangements have been made.

Patient or Responsible Party

Date

CONFIDENTIALITY STATEMENT

Contents revealed in our sessions will be kept in confidence. No information will be released unless I have given written authorization. The exceptions to this policy are outlined in the office privacy practices. They include, but not all-inclusive, situations such as suspected abuse, suicidal or homicidal potential and other legal conditions that require reporting. In emergency situations, verbal authorization(s) will be obtained and followed by written authorization with the situation permits. Individuals or assigned guardians must sign the form.

If there are any persons or agencies with which we may share information with, please indicate below the names of those persons.

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Penny Tanner or Associate _____ Date _____

Client or Guardian _____ Date _____

INFORMED CONSENT & PRESCRIPTION USAGE AGREEMENT

Penny L. Tanner PhD, ARNP
Se Won Min, DNP, PMHNP-BC, ARNP
9116 Gravelly Lake Dr. SW, Suite 107 • Lakewood, WA 98499
253-581-6106
Fax 253-581-6275

NAME OF PATIENT _____ DATE: _____

In order to provide you with the best medical care, AIM Behavioral Health Specialists uses a medication monitoring program. The purpose of the program is to ensure that any drugs you are currently taking are at therapeutic levels to give you the best results and to make sure any additional drugs the physician prescribes will not have a drug-to-drug interaction. Even if you are not currently on medication, the program is there to lower your risk of any adverse reaction to even supplements you might be taking.

Additionally, I UNDERSTAND AND AGREE TO THE FOLLOWING:
That there are federal and state laws, regulations and policies regarding the use and prescribing of controlled substances. **Therefore, medications will only be provided so long as I follow the rules specified in the Agreement. My physician may at any time choose to discontinue the medications. Failure to comply with any of the following guidelines and/or conditions may cause discontinuation of medications.**

- I will disclose to my physician all medications that I take at any time, prescribed by any physician.
- I will use the medications exactly as directed by my physician.
- I agree not to share, sell, or otherwise permit others, including my family and friends, to have access to these medications. I will not allow or assist in the misuse/diversion of my medication.
- I will receive medications only from ONE physician unless it is for an emergency or the medications that are being prescribed by another physician are approved by my physician. Information that I have been receiving medications prescribed by other doctors that have not been approved by my physician may lead to discontinuation of medications.
- **I agree to submit to urine and/or blood or saliva screens** to detect the use of non-prescribed and prescribed medications at any time and without prior warning.
- I hereby give my physician permission to discuss all diagnostic and treatment details with my other physicians and pharmacists regarding my use of medications prescribed by my other physicians.

_____ _____
Patient Signature Date

_____
Provider Signature

INFORMED CONSENT FOR TREATMENT

I _____ (patient/guradian), agree and consent to participate in behavioral health care services offered and provided by AIM Behavioral Health Specialists, a behavioral health care provider. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within: (1) the scope of the provider's license, certifications, and training; or (2) the scope of license, certifications, and training of the behavioral health providers directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Signature _____ Date _____

Relationship to Patient: _____

Current Medical Providers

Patient Name:_____ Date:_____

Please list all of your current medical providers along with their contact information and their specialty.

Provider's Name:_____ Specialty:_____

Business Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Provider's Name:_____ Specialty:_____

Business Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Provider's Name:_____ Specialty:_____

Business Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Provider's Name:_____ Specialty:_____

Business Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Provider's Name:_____ Specialty:_____

Business Name:_____ Phone:_____

Address:_____ Fax:_____

_____

Please let us know if you need an additional form for other providers.