Partners for Behavioral Health and Wellness

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8221 Brecksville Road, #101, Brecksville, OH 44141
Phone: 216.342.4140 FAX: 440.792.4645

Patient Information Form

__ ID Verified

Patient Name: _____ Date:_____ Gender:_____

Address:_____
(Street)

_____
(City) (State) (Zip)

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

Patient DOB:___/___/____ Age:_____ Marital Status:_____ Email:_____

Parent or Guardian _____ Phone _____
(If applicable) (Preferred Phone No.)

Emergency Contact: _____ _____ Relation to Patient _____
(Name) (Phone No.)

Insurance Company_____Phone:_____

Mental Health Carrier:_____Phone:_____
(If different from Primary Insurance Carrier)

Name of Policy Holder:_____ Policy Holder DOB:___/___/___

Relation to Patient:_____

Member I.D./Subscriber #:_____ Group #_____

Employer:_____

Name and phone number of person who referred you to this office (if applicable):

_____

May we contact the person who referred you to this office? _____Yes _____No

May we contact your physician? _____Yes _____No

_____
(Physician Name and Phone Number)

_____
(Physician Address/Location of Office)

May we email an appointment reminder? _____Yes ____No 1 or 2 days before appointment? _____
May we text you an appointment reminder? ____ Yes ___ No If yes, cell phone provider: _____

Do we have your permission to leave you a voicemail message? _____ Yes ____ No

Patient Name:_____

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health treatment depends on efforts of the patient / family / parent / guardian in partnership with the Clinician. In order to maximize treatment effectiveness, the treatment plan can be reviewed and amended at any time by the Clinician in partnership with the client (or patient). I understand that regular attendance is necessary to achieve maximum benefits, although I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I understand that the effectiveness of treatment cannot be guaranteed.

I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality. I also understand that in order to ensure patient confidentiality and privacy, electronic recording of sessions is strictly prohibited within any PARTNERS office unless specific patient authorization is obtained.

My signature below indicates that I have agreed to these terms and have read and understand a "Notice of Privacy Practices" and a "Welcome to Our Practice" information flyer describing my rights and responsibilities as a patient or guardian.

_____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying Partners for Behavioral Health & Wellness (PARTNERS) of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies.

I request that PARTNERS, as the agent for the Clinician, submit bills to the insurance company that I have listed on the reverse side of this form, and I grant permission to the Clinician and PARTNERS to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to PARTNERS to share information related to my insurance claim with the Ohio Department of Insurance. I authorize the release of any medical information necessary to process my claim.

Patient Name:_____

FINANCIAL AGREEMENT (CONT.)

I understand that I am financially responsible for the cost of mental health services to me (my child) and for any portion of the fees not reimbursed or covered by my health insurance. **I understand that my copay is due at time of service.** If my mental health care is provided by a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be determined by the terms of that contract. I understand that my failure to pay balances owed may result in collection procedures (including court proceedings) being taken against me by the Clinician or a collection agency contracted by the Clinician to collect these bills. I also understand that if my account is categorized as "in collections," neither I nor any other patient of PARTNERS for whom I am the guarantor will be able to schedule appointments with any other PARTNERS Clinician. Any fee associated with the collection of this debt is the responsibility of the patient or guarantor, including attorney and filing costs.

I understand that professional services will be rendered to me by _____ (Clinician) and that the fee for an initial consultation will be $_____and the fee for follow- up appointments (37 to 52 minutes) will be $_____.

I also agree to notify the Clinician at least 24 business hours in advance if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged for the full cost of the session, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

I understand that prescribed medication can only be provided in coordination with regular office visits, in order to provide me with safe and appropriate medical care, and that urgent requests by me for **medication refills without an office visit may incur a $25 administrative fee, non-reimbursable by insurance.**

I understand that a materials fee will be incurred when psychological testing is done and that this fee is solely my responsibility and will not be sent to my insurer. Fees may be different for additional services such as psychological testing, legal consultation/testimony, etc. and will be explained to me if these services are necessary. I also agree to return, undamaged, any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials.

My signature below indicates that I have agreed to the above terms.

_____Social Security Number_____ Date_____
(Signature of Patient or Guardian)

FINANCIAL RESPONSIBILITY (IF OTHER THAN PATIENT OR GUARDIAN)

Name_____ ____ Male ____ Female DOB: ___/___/___
Address_____ SSN: _____
_____Phone: _____

_____ _____
(Signature of Financially Responsible Party) (Date)