Alivation Health, L.L.C.

PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Last Name: _____ **First Name:** _____ **MI:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home Phone: (_____)_____ **Cellular:** (_____)_____ **Work Phone:** (_____)_____

Note: By providing us with telephone numbers and addresses, you allow us to contact you at these telephone numbers or addresses.

Email address: _____

Note: You must provide an e-mail to utilize our Patient Portal.

Date of Birth: _____-_____-_____ **SSN:** _____-_____-_____ **Sex: Male** _____ **Female** _____

Marital Status: (circle one) **Married / Single / Widowed / Divorced / Separated** **Preferred Language:** _____

Race:
- _____ **Caucasian or white**
- _____ **Black or African American**
- _____ **Asian**
- _____ **Native Hawaiian or other Pacific Islander**
- _____ **American Indian or Alaska Native**
- _____ **Other**
- _____ **Not reported or refused**

Ethnicity:
- _____ **Hispanic or Latino**
- _____ **Not Hispanic or Latino**
- _____ **Not reported or refused**

Is this visit due to an accident of any kind? Yes or No

Spouse Name: _____

Note: If you would like for your spouse to be able to speak with us about your care you must complete a Release of Information.

Parent/Guardian Name: _____ **Spouse SSN:** _____ - _____ - __

Parent/Guardian Number: _____

PERSON FINANCIALLY RESPONSIBLE: **Same as patient check here:** _____

Name: _____ **Relationship to Patient:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ - _____ - _____ **DOB:** _____ **Employer:** _____

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

Are you covered by an employer's health insurance plan or that of a family member? _____

INSURANCE INFORMATION:

Does your insurance provide benefits for mental health services? _____

Does your insurance require pre-authorization for mental health services? ____ **Do you have authorization?** _____

Does your insurance have a maximum number of visits per year? _____ **If so, how many?** _____

Primary Insurance Company: _____ **Phone Number:** (_____) **Policy Holder's Name:**

DOB: _____ **Relationship to Patient: Policy Number:** _____ **Group Number:** _____

Policy Holder's Employer: _____ **Co-Pay Amount:** _____

Secondary Insurance Company: _____ **Phone Number:** (_____) **Policy Holder's Name:**

DOB: _____ **Relationship to Patient: Policy Number:** _____ **Group Number:** _____

Policy Holder's Employer: _____ **Co-Pay Amount:** _____

Medicaid Patients: **Medicaid Number:** _____

Case worker's name _____ **Phone Number:** (_____)_____

Medicare Patients: **Are you a Veteran?** _____ **Do you have a Federal Black Lung Card?** _____

ALIVATION HEALTH, L.L.C.

INSURANCE RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS:

I authorize Alivation Health, L.L.C. to release to my Medicare carrier or the Insurance carrier provided on Patient Information sheet, any medical information needed for authorization or payment of this or a related claim. I also authorize payments directly to this office for the health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

FINANCIAL AGREEMENT

Pre-Authorization for Mental Health Services:

Most insurance companies require pre-authorization for mental health services, prescription medications, and certain medical treatments. We strongly encourage you to contact your insurance to inquire about any pre-authorization requirements. You may also want to obtain information regarding your health benefits. Most often, health insurance benefits for mental health are different from the benefits for general healthcare. Please contact our billing office should you have any questions regarding the information from your insurance.

Payment of Services:

Patients are required to pay all co-pays, co-insurance and balances on account at the time of service. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. If payment cannot be made when due, you must contact our Patient Accounts Department. After 90 days, if no payment has been received, necessary collection proceedings will begin. It is important that you notify us of any changes of address promptly since undeliverable statements are turned over to collection proceedings immediately.

Insurance:

If you have insurance, Alivation Health will complete and mail an insurance claim on your behalf. However, you are responsible for all pre-authorization requirements, insurance claim follow up, and all charges not covered by your insurance. Please contact your insurance to inquire about the portion of charges they will pay, prior to receiving your first explanation of benefits. It is often the case that insurance benefits for mental health are different from primary care. If you do not receive an explanation of benefits from your insurance company within 30 days of your date of service, please follow up with your insurance on the delayed claim. After you have spoken with your insurance company; please call the billing department at 402-476-6060, to inform us of the progress on the claim. Alivation Health reserves the right to charge the patient the full amount of the visit if there is no response from the insurance company within 45 days. If you have any questions regarding your account or the filing of your insurance claims, please call us at 402-476-6060. We will be happy to assist you.

Appointment No-Show Fee:

I have been advised that this office requires a 24-hour prior notice on all appointment cancellations. I have been advised that there will be a no show fee appointments that are canceled with less than 24 hours notice. This fee is not covered by any insurance plan. Fee varies based on appointment type missed and are updated from time to time, for a breakdown of these fee's please contact the billing department at 402-476-6060.

I understand and agree to abide by the above Insurance Release of Information/Assignment of Benefits and the Financial Agreement.

Patient Name: _____

Signature of Patient/Guarantor: X _____ Date: _____

EMERGENCY CONTACT:

Name: _____ Relationship:

Home Address: _____ City: _____ State: _____ Zip:

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

ALIVATION HEALTH, L.L.C.
AUTHORIZATION FOR MEDICAL TREATMENT, STATEMENT OF RESPONSIBILITY, ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES, PATIENT RIGHTS & RESPONSIBILITIES, and MAGELLAN MEMBER RIGHTS & RESPONSIBILITIES

Patient's Name: _____ **Patient's Date of Birth:** _____

- **Authorization for Medical Treatment**: I authorize the physician(s), psychologist(s), therapists(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Alivation Health, L.L.C. ("Facility). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision of said care.

- **Statement of Responsibility**: I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses.

- **Notice of Privacy Practices:** I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the Facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

- **Patient Rights & Responsibilities:** I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change the Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

- **Magellan Member Rights & Responsibilities:** I have been given the opportunity to review the Magellan Member Rights & Responsibilities and I understand that I may obtain a current copy at the Facility's office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

Patient/Guardian Signature: X _____

Printed Name: _____

Date: _____

ALIVATION HEALTH, L.L.C.

** IMPORTANT PATIENT INFORMATION **

The providers and staff of Alivation Health, LLC feel that we can better serve your health care needs if you are familiar with the following policies and procedures:

Office Hours and Appointments:

The office is open Monday through Friday from 7:30 a.m. to 6:00 p.m. and our telephone hours are 8:00 a.m. to 5:00 p.m. The providers are available on an emergency basis at all times. Follow up appointments should be made when leaving the office. However, appointments may also be scheduled by calling 402-476-6060. When you arrive for an appointment, due to the unscheduled nature emergencies impose upon the providers, occasional delays may occur. We hope that you will understand that these delays are unavoidable.

Cancellations:

If you are unable to keep your appointment, please cancel at least 24-hours prior to your appointment time and we will be happy to reschedule your visit. Some other patient who can be seen during the open time will be grateful for your thoughtfulness. Alivation Health also reserves the right to charge for patient no-shows for medical appointments.

Prescription Refill Requests:

Medications will only be filled during an appointment with your provider. It is important that we closely monitor your medication and therefore, if you need a refill prior to your next scheduled appointment we will require that you schedule a sooner appointment prior to requesting a prescription refill. If a refill is provided it will only cover the days until your scheduled appointment. For refills of medication that require a written prescription, please call our office at 402-476-6060 and select the option for your provider's nurse. For all other medications, please call your pharmacy to request a refill and we will respond to your pharmacy as soon as possible. Please note that most medications require insurance authorization and this process can take 3-4 days. If you miss your appointment, no refills will be given.

Provider Telephone Calls:

You may call our office to ask a question, report a medication side effect, or the worsening of a condition. We will make every effort to return your call as soon as possible. Most often, calls will be returned within 1 business day. All calls received after 3:30 p.m. will be returned the following workday. However, at any time, if a call is urgent, press 1 for the receptionist who will immediately notify the nursing staff of your urgent call. If you encounter a true medical emergency, call 911.

ALIVATION HEALTH, LLC
CONFIDENTIAL PATIENT INFORMATION

Your health is of utmost importance to us. To assist in your evaluation, please fill out this form as accurately as possible. All information will be treated confidentially.

Date: _____

Name: _____ **DOB:** _____

Primary Care Provider: _____ **City/State:** _____

Please explain the reason for your visit and how we can help: _____

_____

IF APPLICABLE, EDUCATION AND SCHOOL HISTORY:

Patient's School: _____ **Patient's Grade in School**: _____

RESEARCH: **Would you be interested in learning about research opportunities**: Yes or No

Do you know anyone else that may want to be contacted regarding research opportunities? Yes or No

Name: _____ Phone Number: (_____)

Name: _____ Phone Number: (_____) _____

REFERRAL INFORMATION: Whom may we thank for referring you to our office?

____Referring Doctor or other medical provider (Name) _____
____Therapist or counseling center (Name) _____
____Hospital, nursing home, or other facility (Name) _____
____Magazine advertisement (Name of magazine)_____
____Friend or Family Member
____Online or website
____Insurance carrier
____Medicaid
____Yellow pages
____School
____Court or juvenile justice office
____None (no referral source)

May we provide your Primary Care Provider and Referring Provider with your individual health information to assist in the coordination of your health care? Yes or No (please circle)

Signature: X _____ **Date:** _____