alivation HEALTH

Patient Information

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

Last Name:_____ First Name:_____ MI:_____

Date of Birth:_____ - _____ - _____ SSN:_____ - _____ - _____ Sex: Male_____ Female_____

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

Email Address:_____ Employer:_____

Home Phone: (_____) _____ Mobile: (_____) _____ Work Phone: (_____) _____

Who is your primary care physician? _____

Emergency Contact:

Name:_____ Relationship to Patient: _____

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

Home Phone: (_____) _____ Mobile: (_____) _____ Work Phone: (_____) _____

Person Financially Responsible

Same as patient check here:_____ Complete the below if someone other than patient:

Name:_____ Relationship to Patient: _____

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

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

Home Phone: (_____) _____ Mobile: (_____) _____ Work Phone: (_____) _____

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

Insurance Information: If you've given a copy to the front desk please disregard the insurance section.

Primary Insurance Company:_____ Phone Number: (_____) _____

Policy Holder's Name:_____ DOB:_____

Relationship to Patient: Policy Number: _____

Secondary Insurance Company:_____ Phone Number: (_____) _____

Policy Holder's Name:_____ DOB:_____

Relationship to Patient: Policy Number: _____

Medicare Patients

Are you a Veteran?_____ Do you have a Federal Black Lung Card? _____

Patient Information

The team at Alivation Health, LLC strives to exceed expectations in treatment and services to make your experience with us as comfortable and stress-free as possible. Please be aware of the following policies:

PLEASE INITIAL EACH ITEM.

___ **PROVIDER:** To ensure you receive the best care, your provider may change during treatment. Reasons for this may include insurance changes, provider specialty, or provider availability.

___ **COPAYMENTS:** Copays are due at the time of service, if you are unable to pay at the time of service you will be asked to reschedule your visit.

___ **SELF-PAY PATIENTS**: If you do not have insurance, your balance is due at the time of your office visit. If you are unable to pay at time of service, you will be asked to reschedule.

___ **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** for 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. **No Show Fees:**

- Behavioral Health Medication Management and Primary Care - $50
- Therapy - $75

___ **INSURANCE CARDS**: Insurance cards are required at every visit. If you have not provided our office with the correct insurance information, you will be responsible for any balance due.

___ **MONTHLY BILLING STATEMENTS**: Every month our office sends out a monthly billing statement to every patient. The balance due is the remainder owed after your insurance has paid.

___ **COLLECTIONS**: If your account balance is unpaid and overdue after three attempts, to contact you and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Once your account is in collections, you will be dismissed from our practice, which includes refill requests and appointments.

___ **PAYMENT PLANS**: If you have negotiated a payment plan with us, you are responsible for making timely and consistent monthly payments. If you fail to make your scheduled due date, your account will be sent to collections for non-payment.

___ **LATE FOR APPOINTMENTS:** If you arrive more than 15 minutes late, we may need to reschedule your appointment or we may ask that you wait until the next open spot in the schedule while we continue to see the patients who arrived on time.

___ **SCREENING LABS:** If a screening lab is done at a physical, some of the charges from the lab may be applied to your deductible depending on individual coverage differences. Please speak with the provider if you would like a limited lab draw instead of the recommended full screening lab.

___ Our staff will treat all patients with the upmost respect and professional attitude. In return, we expect our patients to be courteous in our office. If a patient is consistently uncooperative, refuses to follow treatment plans, or uses demanding and abusive language our staff have the right to dismiss a patient from our practice for non-compliance.

I have read and understand all above policies.

Patient Name (printed)	Patient/Guardian Signature	Date

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Patient Information

Authorization for Medical Treatment, Statement of Responsibility, Acknowledgement of Review of Notice of Privacy Practices, Patient Rights & Responsibilities, and Magellan Member Rights & Responsibilities

Patient Name: _____ Patient 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.

Print Name: _____

Patient/Guardian Signature: _____ Date: _____