Medical Centers
BEHAVIORAL HEALTH CLINIC

Patient Registration **Date:** _____

Name:(First, Last) _____ Perferred Name:_____

D.O.B:_____-_____-_____ SOC. SEC.: _____ - _____ - _____

Street Address:_____ City:_____ Zip:_____

Mailing Address Same: Yes _____ or No _____

Mailing Address :_____ City:_____ Zip:_____

Primary Phone:_____ Email:_____

Patient Employer:_____ Occupation:_____

Appointment Reminder:

This office may leave appointment reminder message on the home or cell phone:

____ Yes ____No Comment:_____

____Yes ____No Text Messaging Appointment Reminders

Insurance Information: (Please Provide Card to be scanned)

Primary Insurance:_____ Contract # _____

Subscriber's Name_____Subscriber's DOB: _____/_____/_____

Secondary Insurance:_____ Contract # _____

Subscriber's Name: _____Subscriber's DOB: _____/_____/_____

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CONTROLLED SUBSTANCE PRESCRIPTION POLICIES

- Controlled substance prescriptions may be used, but only if your medical condition requires them.
- Controlled substance prescriptions will not be replaced if lost or stolen.
- You may be required to submit to random urine drug testing or pill counts before or during treatment with controlled substance medications.
- Your controlled substance prescription may not be refilled/continued if there are abnormalities or irregularities noted at any time with your use of the prescription or urine drug screen results.
- You may not receive any other controlled substance within the same class of medications from any other provider unless first agreed upon. This does not include prescriptions received following a hospital discharge.
- You must agree that your prescriber of controlled substances can, if needed, speak to other providers who are also providing you with any controlled substance prescriptions.
- If your controlled substance prescription does not seem to be helping your condition, you may be tapered off the medication.
- Your controlled substance prescription will not be changed without an appointment.

The policies listed above are so we may better serve you. I agree to the office policies noted above.

Signature: _____ Date: _____

MEDICAL CENTERS BEHAVIORAL HEALTH CLINIC

PRIVACY COMPLIANCE

(Please fill all sections)

CALLS ABOUT MEDICAL /APPOINTMENTS

Please print the telephone number, if any, where you want to receive calls about your appointments, lab, results and/or any other health information.

Primary #: _____ **Secondary #:**_____

If there is someone other than yourself you would like us to be able to talk to about your appointments please list:

_____ Relationship _____ Phone_____

Can confidential messages be left on the numbers above on the answering machine or voicemail? Y/N

MEDICATION PICK UP RELEASE **MARK HERE IF NO ONE_____**

Please list the family members or other persons, if any, that we may allow to pick up your prescription(s) when you are unable to.

Name_____ Relationship_____

MEDICAL HISTORY RELEASE **MARK HERE IF NO ONE _____**

Please list the family members or other person, if any, we may inform about your general medical condition and your diagnosis which might include medical history, treatment, laboratory reports, x-rays, and treatment and/or reference to any mental or nervous disorders, drug and/or alcohol use, or sexually transmitted disease.

_____ Relationship_____ Phone_____

_____ Relationship_____ Phone_____

Are you okay if we talk or send records to your primary care doctor? Yes or No

If yes : Please list them here: _____

Signature: _____ **Date:** _____

Witness:_____ Date:_____

Name: _____ D.o.B: _____

Do you have any allergies? No _____ Yes, please list: _____

_____

Current Medication:

Medication	Dosage	How Often (2/day etc.)

Medical Centers
BEHAVIORAL HEALTH CLINIC

29 Medical Center Lane
Suite A
Guntersville, AL 35976
Office: 256.571.8717
Fax: 256.571.8719

CONSENT TO TREAT

I voluntarily consent to the services and procedures that may be performed during this clinic visit. These may include, but are not limited to laboratory procedures, medical treatment or procedures, and special instructions of my physician. The care may be provided by members of the medical staff or their designees, employees of the hospital and/or authorized agent.

I hereby authorize Marshall Medical Centers to administer such treatment and procedures as my physician may deem necessary or beneficial in the treatment of my condition. Information regarding for the formulation of an Advance Directive (Living Will) shall be provided by the hospital upon my request.

I consent to the taking of pictures of medical condition or treatment, and the use of the pictures for personal identification on my medical record, scientific, educational or safety purposes.

NOTICE OF PRIVACY PRACTICES REGARDING YOUR PROJECTED HEALTH *INFORMATION ACKNOWLEDGMENT OF INFORMATION PROVIDED*

I have read the Protected Health Information (PHI), also known as Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Practices, for medical Centers Behavioral Health Clinic. I understand that Medical Centers Behavioral Health Clinic has the right to change its Privacy Practices at any time and one will be provided to me.**

****PLEASE NOTIFY US IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICES****

NOTICE OF FINANCIAL OBLIGATION AND ASSIGNMENT OF INSURANCE BENEFITS
ACKNOWLEDGEMENT OF INFORMATION PROVIDED AND AUTHORIZATION

I hereby authorize direct payment of medical benefits to Medical Centers Behavioral Health Clinic for services rendered by the physician, in person or under physician's supervision. I understand that I am financially responsible for any balance not covered by my health insurance. I hereby authorize Medical Centers Behavioral Clinic to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefits.

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

Signature: _____
Date: _____

Witness: KERA D HANKINS
Date: PATADMIT

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner. You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you. Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure. There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I want an office visit, not a telehealth visit?

- For now, we are offering both office and telehealth options for appointments.
- However, there may be times due to sickness or high risk of infectious transmission where the office will only do telehealth visits.
- During that time, you must wait until the office opens for all other appointments. We may not know when that will be.

(FLIP OVER)

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
    - Call 256-571-8717 and say you want to stop
    - It will be as if you never signed this form.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

How may telehealth visits can I have?

- We will require that you come into the office for an in person visit at least one time per year. Your provider may decide you need an office visit more often than once a year.

Do I have to sign this document?

- No. Only sign this document if you want to use telehealth. If you do sign this document, we will give you a copy if you want one.

Your signature

Date