Adolescent Patient Information Instructions

Welcome to Premier Behavioral Health Services

Enclosed are patient information forms. Please fill out completely and bring your **Insurance Card(s)** and **Driver License** when you arrive at your appointment so that we may photocopy them.

Bring completed packet, a list of your medications, and your co-pay or deductible. This is required at the time of service or appointment will be rescheduled. We accept CASH, CHECKS, or CREDIT CARDS at this time.

The appointment will be approximately one hour for your first visit. If appointments are not cancelled at least 24 hours in advance, you may be charged a late cancellation fee. If no notification is received, you will incur a no-show fee of $50.00. Please note, no further appointments will be scheduled until this payment has been received.

In case of a minor or an adult under guardianship, a parent or legal guardian must be present at the first appointment. PLEASE NOTE: IF FINANCIALLY RESPONSIBLE PARENT DOES NOT REGULARALY ATTEND APPOITMENTS, A CREDIT CARD MUST BE KEPT ON FILE. AUTHORZATION FORM CAN BE FOUND IN PACKET.
If you are not a biological parent, you must bring in proof of guardianship. **Please do not bring other children with you to this appointment. Children cannot be left unattended.**

Directions to our office

Our office is **east** of 615 on Mentor Avenue. We are on the north side of the street and are located next to Citizens Bank. The office is a brick building and the **entrance driveway** is situated in between our office building and Citizens Bank. Please note that our entrance door and parking lot are in the rear.

Rt. 2

Rt.90

For your first appointment, please arrive 10-15 minutes prior in order to check-in without disrupting your scheduled time.

PREMIER BEHAVIORAL HEALTH SERVICES
Adolescent Personal and Family History

PATIENT INFORMATION Date: _____

Child's Name: _____ ☐ Male ☐ Female

Date of Birth: ___/___/_____ Age: _____ Social Security #: _____-___-_____

Address: _____

City: _____ State: _____ Zip: _____

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

Form Completed By: _____

Relationship to Minor: _____

Financially Responsible Parent to Minor: _____

Address (if different from above):_____ Phone: (____)_____

Where does your child attend school _____

Child's Primary Care Physician_____Phone:_____

Past Illness/Allergies _____

_____

_____

INSURANCE INFORMATION **(MUST BE FILLED OUT COMPLETELY)**

Primary Insurance: _____

Primary Cardholder Name: _____

DOB: ____/_____/_____ Social Security #: _____-____-_____

Patient's Relationship to Primary Cardholder: _____

Insurance ID#: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

Secondary Insurance: _____

Primary Cardholder Name: _____

DOB: ____/____/_____ Social Security #: _____-____-_____

Patient's Relationship to Primary Cardholder: _____

Insurance ID#: _____ Group #: _____

Insurance Company Phone #: _____ Employer: _____

What is the primary reason for seeking treatment for your child? _____

_____

_____

_____

_____

What concern(s) is your child currently experiencing that should be addressed as part of therapy?

_____

_____

_____

_____

MENTAL HEALTH HISTORY

If applicable, please describe your child's previous mental health treatment:

When	Where	Name of Mental Health Professional	Purpose of Treatment	Results	Reason for Terminating Treatment

Is your child currently seeing any other clinician for the above? ☐ Yes ☐ No

If yes, name of provider: _____ Phone: (____) _____

FAMILY RELATIONSHIPS AND SOCIAL HISTORY

Mother's Name: _____ Age: _____ ☐ Birth ☐ Adoptive

Legal Guardian of Child? ☐ Yes ☐ No Lives With Child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed

Name of Spouse/Partner: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

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

Occupation: _____ Place of Employment: _____

Father's Name: _____ Age: _____ ☐ Birth ☐ Adoptive

Legal Guardian of Child? ☐ Yes ☐ No Lives With Child? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Remarried ☐ Widowed

Name of Spouse/Partner: _____

Address (if different from child): _____

City: _____ State: _____ Zip: _____

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

Occupation: _____ Place of Employment: _____

Year Parents Married? _____

Year of Divorce or Separation (if applicable)? _____

What are the current custody/visitation arrangements (if applicable)?

_____

_____

_____

NOTE: Documentation of custody or legal guardianship may also be required.

Do you have significant concerns about your child's relationship with a family member?

☐ No ☐ Yes (please explain): _____

_____

Is your child adopted? ☐ No ☐ Yes

If yes, what year? _____

ADDITIONAL INFORMATION

Please feel free to list any additional information that may be helpful for your child's therapy:

_____

_____

_____

_____

_____

MEDICATION LIST

Name of Medication	Dosage	Prescriber

_____ _____

Parent/Guardian Signature Date

MEDICATION POLICY

During your time at PBHS, you may meet with a prescriber for medications. Always bring a list of your current medications and dosages with you to your appointment. Please make sure this list includes all over-the-counter medications, vitamins and herbs that you currently take.

Please understand that it is your responsibility to take your medication EXACTLY as prescribed. It is also your responsibility to ensure that you obtain your refills in a timely manner. Please allow 72 hours for any refill requests to be filled. We do NOT refill medications on the weekend. Your pharmacy may fax us refill requests at 440-266-0257. For prescription related concerns you may leave a message at 440-266-0770 ext. 124. Please allow 24-48 hours for a return call.

Please understand that we must follow Ohio State Board of Pharmacy and Ohio State Medical and Nursing Board guidelines. This means that in some situations, your medications may not be able to be refilled. You must follow up in the office with your prescriber as instructed to be able to continue with refills. All controlled medications require that you follow up at least every 3 months. Special circumstances may also require regular blood work or other testing be done so that we can monitor and/or adjust the dose of medication if necessary. If you are prescribed a controlled medication, please understand that we reserve the right to perform random drug screening to ensure this medication is being properly utilized.

It is your responsibility to keep your medications in a safe location. If your medication is stolen or misplaced, you need to contact your prescriber immediately. If your prescription has been stolen, we will need a copy of a police report before we can refill your medication.

If it is determined that medication is being misused/abused, your prescriber has the right to refuse further prescriptions and to refer you outside the practice.
Thank you for understanding these policies and for helping us to maintain high quality and safe medical care.

Your signature below acknowledges that you have read and have agreed to our policies.

Signature _____ Date _____

Signature _____ Date _____

Parent/Guardian Signature _____ Date _____

ADOLESCENT CONSENT FOR TREATMENT

Patient Name: _____ D.O.B. _____

Facility: ____PREMIER BEHAVIORAL HEALTH SERVICES_____

Thank you for choosing PBHS for your mental health treatment. The purpose of services through PBHS is to provide assessment, plan for your care, monitor your needs, and to improve quality of life through mental health services. Your initial appointment will be an intake assessment which involves gaining an understanding of your current difficulties and gathering information about your personal history so that we can best develop a plan for treatment. Part of that treatment plan typically involves being scheduled for a therapy appointment and may also include being scheduled for a medication consultation. I give my consent for clinicians of Premier Behavioral Health Services to provide psychiatric consultation and treatment as needed.

Premier Behavioral Health Services is a private multi-disciplinary practice. An Advanced Practice Nurse may also provide an assessment and plan of care, if applicable. It is the policy of this practice to not solely allow medication management unless indicated by a PBHS professional.

Our communication will be confidential and only relevant information will be shared with clinical members of each individualized treatment team. Information will be exchanged between my Psychologist, Counselor, Advanced Practice Nurse, Psychiatrist, and/or Patient Advocate Personnel.

Confidential information may be disclosed if it is necessary for protection from immediate harm.

I authorize any holder of medical or other information about me, including Premier Behavioral Health Services, to release to the Social Security Administration, Health Care Financing Administration or its intermediaries, carriers or state fiscal agents any information need for this or related Medicare/Medicaid claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare/Medicaid assignment of benefit apply.

Patient Name (Please Print) _____

Patient Signature: _____Date:_____

Parent/Guardian Signature: _____Date:_____

ADOLESCENT CONSENT FOR COMMUNICATION

This consent must be signed in order for any associate of Premier Behavioral Health Services to communicate or discuss protected health information about the patient with a *caretaker or family member*. This includes information related to the care or changes to the care a patient has received.

Email Communication: We do not use emails for communication with patients. While you may have an email address for the clinician, it is not utilized for clinical or administrative matters by this practice.

I, *(patient name)* _____, consent to all associates of Premier Behavioral Health Services, which may include the attending Psychologist, Counselor, Advanced Practice Nurse, Psychiatrist, and/or Patient Advocate Personnel to discuss healthcare information about my care to the following people.

Please list any person that Premier Behavioral Health Services may disclose information to:
PLEASE NOTE: REGARDLESS OF PARENTAL PREFERENCE, IF BOTH PARENTS SHARE CUSTODY OF CHILD, BOTH PARENTS MUST BE INCLUDED UNDER CONSENT FOR COMMUNICATION.

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Name: _____ Relationship: _____
Phone: _____

Signature of Patient: _____Date: _____

Signature of Parent/Guardian: _____ Date: _____

Premier Behavioral Health Services
Adolescent Patient Privacy and Contact Information

Patient Name: _____ Birth Date: ____/___/_____

Parent/Guardian Name: _____

How may we contact you?

1. Primary phone number: (_____) _____ Contact Name: _____
   May we leave a message? □ Yes □ No

2. Secondary phone number: (_____) _____ Contact Name: _____
   May we leave a message? □ Yes □ No

Please sign below indicating you have received and reviewed the PBHS Privacy Policy (found on the last page of this packet):

_____ _____ _____ _____
Parent/Guardian Date Child Date

PREMIER BEHAVIORAL HEALTH SERVICES FINANCIAL POLICY

We are dedicated to providing the best possible care for you and want you to completely understand our financial policies. A therapeutic relationship is built on trust and respect. As such, every effort will be made to be on time for your scheduled appointment; we ask that you give the same courtesy if you are unable to keep your appointment. Please read, sign, and date the financial policy below.

1) Payment is due at the time of service.

2) Per PBHS policy, if the financially responsible parent is not actively attending appointments, we require a credit card be kept on file. Please fill out payment authorization form located in packet.

3) Keep in mind that your insurance policy is a contract between you and your insurance company. We will file your insurance claim in a timely manner. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you. Any balance held over 90 days will be sent to a collection agency and could result in a negative mark on your credit rating

4) We do our best to maximize your insurance benefits when filing your claims. However, payment for services, and knowing what is covered, is always the responsibility of the policy holder.

5) Cancellation/ No Show Policy for Appointment
   We understand you may miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, a situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.
   If an appointment is not cancelled at least 24 hours in advance you will be charged a thirty dollar ($30) late cancel fee; this will not be covered by your insurance company. If you provide no notice, you will incur a fifty dollar ($50) no-show fee. You may not reschedule your appointment without payment of this fee.

6) Cancellation/ No Show Policy for Neuropsychological Assessments
   Due to the large block of time needed for neuropsychological assessments, last minute cancellations can cause problems and added expenses for the office.
   If a neuropsychological assessment is not cancelled at least 48 hours in advance you will be charged a hundred and twenty five dollar ($125) fee; this will not be covered by your insurance company. You may not reschedule your appointment without payment of this fee.

_____	_____	____/____/____
Print Name	Patient/Guardian Signature	Date

Patient Account #_____ (Office Use Only)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW YOUR MEDICAL/CLINICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

The information contained in your records is considered sensitive. Please review the following information carefully.

At **Premier Behavioral Health Services** (*PBHS*), we believe your health information/clinical records are personal and contain sensitive information. We maintain a record of the care and services that are provided to you and are committed to keeping this information private, and the law requires that your confidentiality be respected and maintained.

This Notice contains information regarding privacy practices at *PBHS*, and it applies to all the health information that identifies you and the treatment you receive at our practice. This information may consist of paper records, digital or electronic records, as well as possible pictures or videos and other electronic transmissions or recordings that are created as part of your care and treatment. Federal and state laws require us to protect your health information, and federal law further requires us to describe how we handle that information. When federal and state privacy laws are different and conflict with each other, and the state law is more protective of your information or provides you with greater protection to your information, then we follow state law. For example, where we have identified specific state law requirements in this Notice, *PBHS* will follow the more protective state law requirements.

All clinical providers and non-clinical staff at *PBHS* follow the terms of this Notice.

HOW *PBHS* MAY USE AND DISCLOSE YOUR HEALTH INFORMATION

As a patient/client of *PBHS*, your health information will be used in our practice and disclosed outside of *PBHS* for reasons described in this Notice. The following categories describe some of the ways that we will use and disclose your health information.

Treatment/Clinical Care

Health information is utilized to provide you with health care services. We may disclose your information to clinicians in our practice (they include physicians, nurse practitioners, psychologists, psychology assistants, counselors, social workers, chemical dependency counselors, and students in training at the practice.) With appropriate releases, we may disclose your information to other clinicians outside *PBHS*, who may be involved in your care. For example, upon your request, we may provide your primary care physician with information regarding psychotropic medications that a *PBHS* clinician has prescribed you.

Payment

Your health information may be used and disclosed so that the services you receive can be billed and paid by you, your insurance company, or other third parties. For example, we may provide information regarding the care you have been provided so that your insurance company can authorize payment and reimburse for services. We may also tell your health plan about a treatment you will receive so we can get prior authorization/approval or learn if your plan will pay for the treatment.

Health Care Operations

PBHS may use your health information and disclose it outside of our practice for health care operations. These uses are for the purpose of maintaining and improving our services. We may use data from groups of patients to evaluate the efficacy of our programs and measure the performance of our staff. We may also remove information that identifies you to use the data in studying treatment efficacy and other factors in the delivery of behavioral health care.

Contacting you

We may use and disclose health information to reach you about your appointments and other matters. We may contact you by mail, telephone, or email. For example, we may leave voice messages at the telephone number you provided us with, and we may respond to your email address. If there are any of these methods that you do not want to be used, please notify us at the time of your registration as a patient/client at *PBHS*.

Health Information Exchanges

We may participate in certain health information exchanges to disclose your health information, as permitted by law, to other healthcare providers or entities for treatment. These entities may include specialists involved in your care or agencies that may have referred you to us. You will be requested to authorize *PBHS* to provide this information and sign appropriate forms.

Organized Health Care Agreements

PBHS may participate in joint arrangements with other healthcare providers or healthcare entities whereby we may use or disclose your health information, as permitted by law in joint activities involving treatment, review of healthcare decisions, quality assessment, and/or payment activities.

Psychiatric and Psychological Research

PBHS is a learning organization, and at times, we conduct research that may involve evaluating the outcome of services or another related topic that could include your health information. All research conducted at *PBHS* is evaluated and approved by a clinical leadership committee consisting of the Medical Director and the Clinical Director to ensure that it meets appropriate standards of practice, including privacy. We will not use your health information without your approval and maintain that your privacy is protected.

Organ and Tissue Donation

We may release health information about organ, tissue, and eye donors and transplant recipients to organizations that manage organ, tissue, and eye donations and transplantation.

Public Health and Safety

PBHS will disclose health information about you outside of *PBHS* when required to do so by federal, state, or local law or under a court order. We may provide health information about you for public health and safety reasons, like reporting child abuse or neglect, reaction to medications, or problems with medications. We may release health information to help control the spread of disease or notify a person whose health or safety may be threatened. We may also disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure and accreditation. We may disclose health information about you in the event of an emergency or for disaster relief purposes.

Authorization for Other Uses and Disclosures

As described above, we will use your health information and disclose it outside *PBHS* for treatment, payment, health care operations, and when required or permitted by law. *PBHS* will not use or disclose your health information for other reasons without your written consent and authorization. For example, most uses, and disclosures of psychotherapy notes, uses and disclosures of health information for specific marketing purposes, and disclosures that constitute a sale of health information require your written authorization. *PBHS* will make these kinds of uses and disclosures of your health information only with your written authorization. You may revoke the authorization in writing at any time, but we cannot take back any uses or disclosures of your health information already made with your permission.

Federal law may require that we obtain your consent for specific disclosure of health information about the followings: the performance or results of an HIV test or diagnosis of AIDS or an AIDS-related condition, genetic test results, drug or alcohol treatment that you have received as part of a drug or alcohol treatment program.

YOUR RIGHTS REGARDING HEALTH INFORMATION

Right of Accounting

You may request an accounting, which is a listing of the entities or persons (other than yourself) to whom *PBHS* has disclosed your health information without your written authorization. The account would not include disclosures for treatment, payment, healthcare operations, and certain other disclosures exempted by law. Your request for an accounting of disclosures needs to be in writing, signed, and dated. It must identify the time period of disclosure and *PBHS*, which is the holder of the records. We will not list disclosures made earlier than six years before your request.

Your request should indicate the method in which you request the list (for example, on paper or electronically). The request needs to be in writing and submitted to *PBHS* to the attention of:

Premier Behavioral Health Services
Attn: Medical Records
8701 Mentor Avenue
Mentor, Ohio 44060

Right to Amend

If you feel that the health information we have about you is incorrect or incomplete, you have the right to ask us to amend your medical records. Your request for an amendment must be in writing, signed, and dated. It must specify the records you wish to amend and provide the reason for your request. We may deny your request; if we do, we will inform you why and explain your options. *PBHS* will respond to you within 60 days. Please submit your request to:

Premier Behavioral Health Services
Attn: Medical Records
8701 Mentor Avenue
Mentor, Ohio 44060

Right to Inspect and Obtain a Copy

You have the right to inspect and obtain a copy of your completed health records unless your provider believes that disclosing that information to you could harm you. You may not see or get a copy of the information gathered for a legal proceeding. Your request to inspect or obtain a copy of your records must be submitted in writing, signed, and dated. We may charge you a fee, based on our cost, for processing your request. (continued on next page)

(Right to Inspect and Obtain a Copy continued)

If *PBHS* denies your request to inspect or obtain a copy of your records, you may appeal the denial in writing to:

Premier Behavioral Health Services
Attn: Clinical Director
8701 Mentor Avenue
Mentor, Ohio 44060

Right to Request Restrictions

You have the right to ask *PBHS* to restrict the uses or disclosures we make of your health information for treatment, payment, or health care operations, but we do not have to agree in some circumstances. However, if you pay out-of-pocket and in full for services you receive, and you ask us to restrict the disclosure to a health plan of your health information relating solely to that service, we will agree to the extent that the disclosure to the health plan is to carry out payment or healthcare operations and the disclosure is not required by law. You may also ask us to limit the health information that we use or disclose about you to someone involved in your care or the payment for your care, such as a family member or friend. Again, we do not have to agree. The request for a restriction must be signed and dated. The request should also describe the information you want to be restricted if you wish to limit the use or the disclosure of the information or both and tell us who should not receive the restricted information. You must submit the request in writing to *PBHS*. We will notify you if we agree with your request or not. If we agree, we will comply with your request unless this information is needed to provide you with emergency treatment. Please submit your request to:

Premier Behavioral Health Services
Attn: Clinical Director & Medical Records
8701 Mentor Avenue
Mentor, Ohio 44060

Right to Request Confidential Communications

You have the right to request that we communicate with you about your health in a certain way or at a specific location. For example, you can ask that we only contact you at work or by mail. Your request for confidential communications must be in writing signed and dated. It must also specify how or where you wish to be contacted. You do not need to tell us the reason for your request, and we will not ask. You must send your written request to *PBHS*. (continued on next page)

(Right to Request Confidential Communications continued)

We will accommodate all reasonable requests. Please submit your request to:

Premier Behavioral Health Services
Attn: Medical Records
8701 Mentor Avenue
Mentor, Ohio 44060

Right to a Paper Copy of This Notice

You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to the paper copy. You may obtain a paper copy of this Notice at *PBHS* or print it from our website at https://pbhsohio.com.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with *PBHS'* Compliance Officer or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with *PBHS*, you must submit your complaint in writing to the Compliance Officer of PBHS. You will not be penalized for filing a complaint. Please submit your request to:

Premier Behavioral Health Services
Attn: Compliance Officer
8701 Mentor Avenue
Mentor, Ohio 44060

CHANGES TO THIS NOTICE

PBHS may change this Privacy Practice Notice at any time. Any changes in the Notice could apply to health information we already have about you and any information we receive in the future. We will post a copy of the most current Notice on our website at https://pbhsohio.com.

QUESTIONS

If you have any questions about this Privacy Practice Notice, you may call *PBHS* at (440) 266-0770 and ask to speak with the Compliance Officer.