Augusta Health Outpatient Behavioral Health Services rev.8/13

79 N. Medical Park Drive, Fishersville, VA 22939 Phone 540-213-2525 Fax 540-213-2555

PATIENT NAME_____ Today's Date _____
DATE OF BIRTH_____SocSec #_____
HOME PHONE NUMBER _____ Cell # _____
ADDRESS _____
_____

How did you hear about our services? _____

Next of Kin_____Relationship_____
Address of Next of Kin_____
Phone Number (Next of Kin) _____
Your Insurance Information_____
Name of Subscriber: _____
Your Employer or Occupation_____ Retired Disabled
Employer Address_____
Employer Phone_____

--Medical Information--

Primary Care Physician_____
Do you use Tobacco? Yes Never Past If current, how often?_____
Do you use Alcohol? Yes Never Past If current, how often?_____

Allergies		List of Medications w/Dosages									
		Dates of Reviews→	new								
List Medical Problems & Past Surgeries BELOW											

FOR OFFICE USE ONLY: ENTERED ON SYSTEM BY_____ON_____

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AUTHORIZATION TO OBTAIN/RELEASE/EXCHANGE *HEALTH/TREATMENT INFORMATION*

I, _____ hereby authorize AH Outpatient Behavioral Health Services to release to, receive from, or exchange with the names below (or you may decline and, write "NO".):

1. My Primary Care Physician (PCP)_____
2. Other Mental Health Provider(s) _____
3. Insurance Company/Managed Care Company _____
4. Family/Other _____

This authorization pertains to any portion of my medical record, including alcohol/drug treatment, and mental health information, and is intended to be used for **insurance authorization, treatment planning, and follow-up care.**

This authorization begins today and expires one **(1) year** from my last appointment with AH **Outpatient Behavioral Health Services**. I understand I may revoke this authorization at any time by providing a written statement to the Office Coordinator *at the above office location*.

The information furnished is prohibited for any purpose other than that stated above AND the recipient is prohibited from disclosing this information to any other party, except as allowed or required by law or regulation. Therefore, information released by us may be subject to redisclosure and might no longer be protected.

A photocopy of this document has the same authorization as the original.

I understand if I have questions about disclosure of my health information, I can contact the Office Coordinator *or Director* at the *above address or phone/fax numbers*.

Circle you answer about wanting Appointment Reminder Calls: YES NO

These automated calls are generally made the day before your appointment, on Saturday for Monday appointments.

If YES, please use this phone number:_____

_____ _____

Patient Signature Date

_____ _____ _____

Guardian/Personal Representative Signature Relationship Date

_____ _____

Witness Signature Date

Outpatient Behavioral Health Services
79 North Medical Park Drive, Fishersville, VA 22939
Phone: 540-213/941-2525 Fax: 540-213/941-2555

This form has two (2) parts.

Print Name _____ Date of Birth _____

Part 1: **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE**

RELEASE OF HEALTH INFORMATION / NOTICE OF PRIVACY PRACTICES

I understand that this provider office may release and receive information from my medical record and billing records in accordance with the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and statutory regulations of the Commonwealth of Virginia. My signature below acknowledges that I have received a copy of the federal Notice of Privacy Practices at or prior to this service encounter.

Part 2: **OUR POLICY about MISSED APPOINTMENTS**

Psychotherapy/counseling sessions require a block of time be reserved. Unlike regular medical appointments, we do not "double-book" patients, and cannot offer the time to someone else unless we receive adequate cancellation notice.

A non-Medicaid patient who does not provide timely notification for missing an appointment **may be charged a fee of $20**, **NOT covered by AH Financial Aid or insurances.** For any patient, the professional relationship risks ending when another appointment is missed without notice. The alternative option for a clinician is you can be placed in "Same Day Appointment" status: meaning, you call the day you can make it in and the staff will see if that clinician *or another* has an opening.

1. We offer patients the option of a **reminder call** the day before an appointment. If you choose this, be sure we have your most current phone number, and let us know when it changes!
2. Patients are expected to give **24 hours notice** to cancel, unless there's an accident or sudden illness. You must phone in by 8 a.m. for that day's appointment. Otherwise, it is a "Late Cancellation" and can also result in reduced access to appointments with that clinician.
3. Our office phone number with **voicemail** makes cancellation possible any time of day or night.
4. Payment of "NO-SHOW" or "LATE CANCELLATION" fee is due at the next appointment.

Signature of Patient / Responsible Party _____ Relationship _____

Witness (Staff) _____ Date _____

08/14/17; rev 7/5/18