

Avalon Behavioral Health, PLC

Growth Revealed Through Change

491 E. Columbia Ave. Ste. 4, Battle Creek, MI 49014 – Phone (269)962-9611 – Fax (269)962-9612

Personal Information (Please Print)

Client's Name _____ Birthdate ____/____/____

Parent/Guardian Name (if minor) _____

Address _____

City _____ State _____ Zip _____

Telephone (Cell) _____ (Work) _____ (Home) _____

Age ____ Sex _____ Gender Identity _____ Ethnicity _____

Marital Status _____ Religious Affiliation _____

Veteran _____ Employer _____

Email _____

In case of emergency, contact: _____ Phone _____

Relationship to client _____

History

Legal History _____

Substance Abuse History _____

Highest Level of Education _____ Developmental Delays _____

If Student provide name of school _____

Teacher's name/may we contact _____

Past Psychiatric Hospitalization _____

Past Mental Health Issues _____

Referral Source

How did you hear of our clinic (or from whom)? _____

Reason for Referral _____

Physician _____ Phone _____

Psychiatrist _____ Phone _____

Current Medications _____

****Please complete each form prior to the scheduled appointment. If the forms are not completed and signed appropriately, it may result in your appointment needing to be rescheduled. Thank you.**

Signature _____ Date _____

Insurance Information

Primary Insurance _____ Secondary Insurance _____
Subscriber _____ Subscriber _____
Subscriber Date of Birth _____ Subscriber Date of Birth _____
Relationship _____ Relationship _____
Phone _____ Phone _____
Contract/ID# _____ Contract/ID# _____
Group/Acct# _____ Group/Acct# _____
Employer _____ Employer _____

Patients relationship to Responsible Party: Self Partner Child Other

AUTHORIZATION TO BILL INSURANCE

I, _____, hereby give my consent for Avalon Behavioral Health to bill my/my child’s insurance carrier for the services rendered to me/ my child/family by the above-mentioned provider. In addition, I agree to pay Avalon Behavioral Health any deductibles or uncovered charges in accordance with my health care plan.

Client/Guardian Signature _____

Relationship to Client _____ Date _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I, _____, understand that my consent is required to release any health care information relating to testing, diagnosis, and/or treatment for mental health disorders, drug, and/or alcohol abuse. I hereby give my consent to Avalon Behavioral Health to release information to:

- Insurance Company
- Family Physician (Please provide name) _____
- Referring Physician Please provide name) _____
- Family Member(s) _____
- Other _____

Client/Guardian Signature _____

Relationship to Client _____ Date _____

Consent to Treatment and Recipients Rights

Client _____ Date _____

I, _____ (relationship if minor) _____ the undersigned, hereby attest that I have voluntarily entered into treatment, or give my consent and have the legal right to consent for the minor or person under my legal guardianship mentioned above, at **Avalon Behavioral Health, PLC**. Further, I consent to have treatment provided by a psychologist, social worker, counselor, or intern in collaboration with his/her supervisor. The rights, risks, and benefits associated with treatment have been explained to me. I understand that therapy may be discontinued at any time by either party. The clinic encourages that this decision be discussed with the treating psychotherapist. This will help facilitate a more appropriate plan for discharge.

Recipient's Rights: I certify that I have received the Recipient's Rights pamphlet and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information from the Office Manager.

Non-voluntarily Discharge from Treatment: A client may be terminated from **Avalon Behavioral Health, PLC** non-voluntarily, if: (A) the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal acts at the clinic, and/or (B) the client refuses to comply with stipulated program rules, refuses to comply with treatment recommendations, or does not make payment or payment arrangements in a timely manner. The client will be notified of the non-voluntary discharge by letter. The client may appeal this decision with the Clinic Director or request to reapply for services at a later date.

Client Notice of Confidentiality: The confidentiality of patient records maintained by **Avalon Behavioral Health, PLC** is protected by federal and/or state law and regulations. Generally, **Avalon Behavioral Health, PLC** may not say to a person outside the clinic that a patient attends therapy or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) the patient consents in writing, (2) the disclosure is allowed by a court order, or (3) the disclosure is made to medical personnel in a medical emergency, or to qualified personnel for auditing purposes or program evaluation.

Violation of federal and/or state law and regulations by a treatment facility or provider is a crime. Suspected violations may be reported to appropriate authorities. Federal and/or state law and regulations do not protect any information about a crime committed by a patient either in the clinic, against any person who works for the **Avalon Behavioral Health, PLC**, or about any threat to commit such a crime. Federal law and regulations do not protect any information about suspected child (or vulnerable adult) abuse or neglect from being reported under federal and/or state law to appropriate state or local authorities. Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful. It is **Avalon Behavioral Health, PLC's** duty to warn any potential victim when a significant threat of harm has been made. In the event of a client's death, the spouse or parents of a deceased client may have a right to access their child's or spouse's records. Professional misconduct by a health care professional must be reported by other health care professionals, in which related client records may be released to substantiate disciplinary concerns. Parents or legal guardians of non-emancipated minor clients have the right to request the client's records, however, it could be denied.

When fees are not paid in a timely manner, a collection agency will be given appropriate billing and financial information about the client, not clinical information.

My signature below indicates that I have been given a copy of my rights regarding confidentiality. I permit a copy of this authorization to be used in place of the original. I consent to treatment and agree to abide by the above-stated policies and agreements with **Avalon Behavioral Health, PLC**.

Signature of Client/Legal Guardian

Date

(In a case where a client is under 18 years of age, a legally responsible adult acting on his/her behalf)

Witness

Date

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Financial Policy

The staff at Avalon Behavioral Health (hereafter referred to as ABH) is committed to providing caring and professional mental health care to all of our clients. As part of the delivery of mental health services, we have established a financial policy that provides payment policies and options to all consumers. The financial policy of ABH is designed to clarify the payment policies as determined by the management of the clinic.

The Person Responsible for Payment of Account is required to sign the form Payment Contract for Services, which explains the fees and collection policies of ABH. Your insurance policy, if any, is a contract between you and the insurance company; we are not part of the contract with you and your insurance company.

As a service to you, ABH will bill insurance companies and other third-party payers but cannot guarantee benefits or the amount covered and are not responsible for the collection of such payments. In some cases, insurance companies or other third-party payers may consider certain services as not reasonable or necessary or may determine that services are not covered. In such cases, the Person Responsible for Payment of Account is responsible for payment of these services. We charge our clients the usual and customary rates for the area. Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates.

The Person Responsible for Payment (as noted in the Payment Contract for Services) will be financially responsible for payment of such services. The Person Responsible for Payment of Account is financially responsible for paying funds not paid by insurance companies or third-party payers after 30 days. Payments not received after 90 days are subject to collections.

Insurance deductibles and co-payments are due at the time of service. Although it is possible that mental health coverage deductible amounts may have been met elsewhere (e.g., if there were previous visits to another mental health provider since January of the current year that were prior to the first session at the clinic), this amount will be collected by ABH until the deductible payment is verified to ABH by the insurance company or third-party provider.

All insurance benefits will be assigned to ABH (by insurance company or third-party provider) unless the Person Responsible for Payment of Account pays the entire balance each session.

Clients are responsible for payments at the time of services. The adult accompanying a minor (or guardian of the minor) is responsible for payments for the child at the time of service. Unaccompanied minors will be denied nonemergency service unless charges have been preauthorized to an approved payment plan, charge card, or payment at the time of service.

Cancellations with less than 24 hours' notice will be charged a fee of \$15.00 and a fee of \$35.00 will be charged for missed appointments without notice.

Payment methods include check, cash, or credit card.

I (we) have read, understand, and agree with the provisions of the Financial Policy.

Person responsible for account: _____ Date: ____/____/____

Co-responsible party: _____ Date: ____/____/____