Aloha Behavioral Consultants, Inc.
REGISTRATION FORM

CONFIDENTIAL

TODAY'S DATE:	**PRIMARY CARE PHYSICIAN:**

PATIENT INFORMATION

Patient's last name:	First:	MI:	

Is this your legal name? Y / N	If not, what is your legal name?	Birth date:	Age:	Sex: ❑ M ❑ F

SS#	Home Phone #:	Cell Phone #:	Marital status (circle one) Single / Mar / Div / Sep / Widow

Address:	How were you referred to Aloha Behavioral Consultants?

City:	State:	ZIP Code:	

Employer:	Occupation
Do you want reminder calls? Yes No Ph # for Reminders:	
Email address:	

Person Responsible for Bill (if other than patient):		Relationship:
Address (if different for statements):	Phone #:	
Employer:	DOB:	SS#:

INSURANCE INFORMATION

Please complete all information even if we already have some of it. Please give your insurance card to the receptionist to copy.

Is this patient covered by insurance? Y / N	Is this an EAP benefit? Y / N	**EAP Company:**
EAP Authorization Number:		EAP Phone#:

Primary Insurance:	Insurance Phone #:	Insurance Auth #:
Subscriber's name:	Employer:	Date of Birth:
Patient's relationship to subscriber:	Policy/ID number:	Group #:
Subscriber Address (if different):	Have you met your deductible? Y / N	Co-payment: $

Secondary Insurance (if applicable):	Insurance Phone #:	Insurance Auth #:
Subscriber's name:	Employer:	Date of Birth:
Patient's relationship to subscriber:	Policy/ID number:	Group #:
Subscriber Address (if different):	Have you met your deductible? Y / N	Co-payment: $

Emergency Contact - Name & address of local person not living at same address:	Relationship to patient:	Phone #:

The above information is true to the best of my knowledge. I give consent to receive psychotherapy services at Aloha Behavioral Consultants. I authorize my insurance benefits be paid directly to the physician. **I understand that it is my responsibility to obtain proper authorizations for service.** I understand that I am financially responsible for any balance. I also authorize ABC or insurance company to release any information required to process my claims. All co-pays are due at time of service unless other arrangements have been made. A minimum of 24 hours notice is required for the cancellation of any appointment. A finance charge of 1.5% will be added monthly on any overdue accounts. All accounts over 90 days will be referred to collections. Client agrees to pay any and all attorney, collection, and court fees incurred.

Patient or Guardian Signature *Date*

Aloha Behavioral Consultants, Inc.
811 North Harrisville Road
Harrisville, UT 84404
Office 801-399-1818*Fax 801-782-8412**

Consent for Psychological Services for Minor

Name of Person Giving Consent:_____
Your Relationship to Child (check one):

[ ] Parent [ ] Stepparent [ ] Grandparent
[ ] Guardian [ ] Other:_____

Name of Child:_____ Date of Birth:_____

I, _____, consent to the following psychological/psychiatric services with Aloha Behavioral Consultants, Inc. for the child named above:

Check and Initial All That Apply

[ ] Clinical Interview/Evaluation
[ ] Counseling/Psychotherapy
[ ] Other _____
[ ] Psychological Testing
[ ] Psychiatric Evaluation

_____ _____
Signature of person giving consent Date

_____ _____
Signature of person giving consent Date

_____ _____
Signature of Witness Date

ALOHA BEHAVIORAL CONSULTANTS, INC.
lNFORMED CONSENT FOR PSYCHOTHERAPY
and PATIENT RIGHTS AND INFORMATION

I, _____, have reviewed the various aspects of this psychotherapy contract as follows. This will include a discussion of the therapist's evaluation and diagnostic formulation, as well as the method of treatment. The nature of the treatment will be described, including the extent, and possible alternative forms of treatment. I understand I may withdraw from treatment at any time but if I decide to do this I will discuss my plan with my therapist before acting on it.

Aloha Behavioral Consultants, Inc. has further discussed with me scheduling policies, fees to be charged, and policies regarding payment, missed appointments, matters relating to insurance, and if applicable, pre-authorization and utilization review issues.

Some important issues regarding confidentiality need to be understood as we begin our work together. Please review this material carefully so that we may discuss any questions or concerns of yours the next time we meet.

In general, the confidentiality of all communications between a patient and psychologist is protected by law, and I can only release information about our work to others with your written permission. There are a few exceptions, however.

In most judicial proceedings you have the right to prevent me from testifying. However, in child custody proceedings, adoption proceedings, and proceedings in which your emotional condition is an important element, a judge may require my testimony if it is determined that resolution of the issues before the court requires it. If you are involved in litigation, or are anticipating litigation, and you choose to include your mental or emotional state as part of the litigation, I may have to reveal part or all of your treatment or evaluation records.

If you are called as a witness in criminal proceedings, opposing counsel may have some limited access to your treatment records. Testimony may also be ordered in (a) legal proceeding relating to psychiatric hospitalization; (b) in malpractice and disciplinary proceedings brought against a psychologist; (c) court-ordered psychological evaluations; and (d) certain legal cases where the client has died.

In addition, there are some circumstances when I am required to breach confidentiality without a patient's permission. This occurs if I suspect the neglect or abuse of a minor, in which case I must file a report with the appropriate State agency. If, in my professional judgment, I believe that a patient is threatening serious harm to another, I am required to take protective action which may include notifying the police, warning the intended victim, or seeking the client's hospitalization. If a client threatens to harm him or herself, I may be required to seek hospitalization for the client.

The clear intent of these requirements is that a clinician has both a legal and ethical responsibility to take action to protect endangered individuals from harm when his or her professional judgment indicates that such danger exists.
There are several other matters concerning confidentiality:

1. I may occasionally find it helpful or necessary to consult about a case with another professional. In these consultations I make every effort to avoid revealing the identity of the client. The consultant is, of course, also legally bound to maintain confidentiality. If I feel that it would be helpful to refer you to another professional for consultation then, of course, with your authorization, I will discuss your case with her or him.

2. I am required to maintain complete treatment records. Patients are entitled to receive a copy of these records, unless I believe the information would be emotionally damaging and, in such cases, the records request may be denied. Patients will be charged an appropriate fee for preparation.

3. If you use third party reimbursement, I am required to provide the insurer with a clinical diagnosis and sometimes a treatment plan or summary.

4. If you are under eighteen years of age, please be aware that while the specific content of our communications is confidential, your parents have a right to receive general information on the progress of the treatment.

5. Under current Utah law, in group and family therapy and in marital therapy all participants are required to consent to the release of information. One marital partner may not waive privilege for another. In cases of marital therapy, therefore, the record may be released only if both parties waive privilege or release of the record is court ordered.

While this summary of exceptions to confidentiality should prove helpful in informing you about potential problems, you should be aware that the laws governing these issues are often complex and I am not an attorney. I encourage our active discussion of these issues. However, if you need more specific advice, formal legal consultation may be desirable. If you request, I will provide you with relevant portions or summaries of the applicable State laws governing these issues.

RIGHTS OF CONSUMER

You have certain rights provided for you by the State of Utah:

1. privacy of information and privacy for both current and closed records,
2. reasons for involuntary termination and criteria for re-admission to the program,
3. freedom from potential harm or acts of violence to consumer or others,
4. consumer responsibilities, including household tasks, privileges, and rules of conduct,
5. service fees and other costs,
6. grievance and complaint procedures,
7. freedom from discrimination,
8. the right to be treated with dignity,
9. the right to communicate by telephone or in writing with family, attorney, physician, clergyman, and counselor or case manager except when contraindicated by the licensed clinical professional,
10. a list of people, whose visitation rights have been restricted through the courts,
11. the right to send and receive mail providing that security and general health and safety requirements are met,
12. defined smoking policy in accordance with the Utah Clean Air Act, and
13. statement of maximum sanctions and consequences, reviewed and approved by the Office of Licensing.

APPOINTMENT TIMES

We will set a specific time for your therapy. Be prompt. If you are late, you are losing valuable time with your therapist. We value your time and do not want you to wait needlessly. We will do our best to be timely also. Understand that emergencies take precedence and may affect our scheduling.

CASH PATIENT FINANCIAL POLICY

We **require** that 100% of the visit to be paid at the time of the visit. We are happy to accept cash, check, or credit card.

CANCELLATION POLICY_____Initial

If you are unable to keep your appointment, you are required to give your therapist 24 hour notice as a professional courtesy or reschedule your appointment for the same day if there are appointment times available. Your therapist's time is dedicated to you for that time and it is costly to the therapist and other clients if that hour is un-utilized.
Cancellations or no shows less than 24 hours in advance will result in a $40 fee being charged to your account. Should your appointment be rescheduled for another day, you will still be charged for a cancellation. Please understand that this fee minimally covers administrative costs to keep our services available to you and to keep our business open.
Should you miss three appointments, you will forfeit your privilege to see a therapist here for six months.
We understand that there are occasional emergencies that will not allow you to give us 24 hours notice. In this RARE circumstance, please inform the office as soon as possible and your therapist may request a waiver from administration for the fees.

CONTACTING YOUR THERAPIST_____Initial

In the event that you need to contact your therapist other than during your session for a clinical concern, email is the best form of contact. Your therapist will do their best to respond timely. Please understand that your therapist may not work every day here and a response may take up to one week. The majority of your questions can be handled at the Front Desk. Please contact them first and they can address any of your concerns.

COLLECTIONS

I am aware and agree that in the event that my account is turned over for collection, a monthly finance charge of 1.5% per month will be imposed on all goods and services not paid for within 30 days. This is an annual percentage rate of 18%. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs.

I have read the above; fully understand the diagnosis, the nature of treatment, the alternatives to this treatment, the limits of confidentiality in this relationship, and the circumstances in which confidential communications may need to be breached. Having been informed, I consent to psychotherapy treatment with Aloha Behavioral Consultants.

_____ _____

Signature Date

ALOHA BEHAVIORAL CONSULTANTS, INC.
811 North Harrisville Road
Harrisville, UT 84404

Consent for Use of Disclosure of Health Information

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure to understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health information.

1. We may have to disclose your health information to another care provider or a hospital if it is necessary to refer you to them for your diagnosis, assessment, or treatment.
2. We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of the services.
3. We may need to use your health information within our practice for quality control or other operational purposes.
4. We may need to use your personal information to remind you of your appointments.

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before you sign this consent form.

We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you writing when you come for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notice.

Your right to limit uses or disclosures
You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations, if you would like to place any restrictions on the use or disclosure of your health information, please let us know in writing. We are not required to agree to restrictions. However, if we agree with your restrictions, the restriction is binding upon us.

Your right to revoke your authorization
You may revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to its terms I am also acknowledging that I have received a copy of this notice.

_____
Print Name

_____ _____
Signature Date

ALOHA BEHAVIORAL CONSULTANTS, INC.
811 North Harrisville Road
Harrisville, UT 84404

ASSIGNMENT OF BENEFITS

The undersigned patient and/or responsible party, in addition to continuing personal responsibility, and in consideration of treatment rendered or to be rendered assigns the physician or facility named above the following rights, power, and authority.

RELEASED INFORMATION: You are authorized to release and to permit the examination or copying of any of my medical records, progress reports, x-rays, laboratory reports, and the results of all tests of any type or character to such person(s) as the physician and/or facility deems appropriate.

ASSIGNMENT OF RIGHTS: You are assigned to exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for benefits to the extent of your bill for total services if such benefits are owed within the terms of the policy, including the exclusive, irrevocable right to receive payment for such services, make demand in my name for payments, and prosecute and receive penalties, interest, court costs, or other legally compensable amounts owed by an insurance company. I, as the patient and/or responsible party, further agree to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request. The physician and/or facility is also assigned the exclusive, irrevocable right to request and receive from any insurance company or health care plan any and all information and documents pertaining to my policies including a copy of such policy, and any information or supporting documentation concerning or touching u8pon the handling, calculation, processing, or payment of any claim.

DEMAND FOR PAYMENT: To any insurance company providing benefits of any kind to me/us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician/facility named above following your receipt of such bill for services to the extent such bills are payable under the terms of my/our policy for benefits, less any amounts I/we owe personally which are not payable under the terms of your policy.

THIRD PARTY LIABILITY: If patients(s) treatments for injuries are the result of the negligence of any third party, then patient(s) grant a lien against any recovery from such third party(s) to the extent of the bills for treatment in favor of the physician/facility named above.

STATUTE OF LIMITATIONS: Patient(s) waive the right to claim any Statute of Limitations regarding claims for services rendered or to be rendered by the physician/facility named above, in addition to reasonable costs of collection including attorney fees and court costs in incurred. I also agree to pay a minimum finance charge of 1.5% per month (annual percentage rate of 18%) or a minimum of $2.00 whichever is more on any amount not paid after 30 days. If collection is made by suit or otherwise, patient and/or responsible party agrees to pay interest until paid, collection costs of 50% of the remaining balance, all attorney fees and court costs.

LIMITED POWER OF ATTORNEY: I hereby grant to the physician/facility named above power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and health care rendered by physician/facility. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my/our account or forwarded to my/our address upon request in writing to the physician/facility named above.

In the event that any provision of this Agreement is determined invalid or unenforceable, all other provisions of this Agreement shall remain enforceable.

A PHOTOCOPY OF THIS INSTRUMENT SHALL SERVE AS ORIGINAL

Signature of Patient or Responsible Party:

_____ Date_____