Altahir Behavioral Health PLC

Patient Registration Form

Referred by:_____

Patient's Name _____ ◯ Male ◯ Female
Last First Middle Int.

SS#:_____DOB_____ Age____ Marital status ◯S ◯M ◯D ◯W

Address: _____ APT# _____

City _____ State _____ Zip code _____

Home Telephone _____ Cell phone _____

Email Address _____

Employer Name _____ Occupation _____

Address _____ City _____ State _____ Zip code _____

Emergency Contact _____ Relation _____

Telephone_____

Please fill the below if you are responsible for a patient under 18 years old:

Name: _____Relationship _____

DOB: _____ SS# _____Cell phone _____

Occupation _____ Address_____

Insurance Information:

Primary insurance_____ Policy holder Name _____

DOB (of policy holder)_____ SS#_____ Relationship _____

Secondary insurance_____ Policy holder Name _____

DOB (of policy holder) SS# Relationship

Pharmacy Information:

Name: _____ Phone: _____ Fax_____

Address: _____

Altahir Behavioral Health PLC. Office Policies

It is our goal at Altahir Behavioral Health to serve you in a caring and professional manner. We feel it would be helpful to make you aware of the following:

Initial after reading each statement.

- Confidentiality is a very important part of treatment. Please know that no information will be released to any persons that do not have prior consent from patient or guardian.
- **All late, canceled, and missed appointments are subject to a fee of $50.00. We require 24 hour notice to be given. This charge will be due at your next appointment.**
- All Co-Pays, Deductibles, or any amount not covered by your insurance company will be expected at the time of your appointment.
- Please contact your pharmacy for prescription refill request and have them faxed to our office. Please allow 48 hours for providers response of refill request to be sent to your pharmacy and allow 72 hours for prescription prior authorization completion.
- If two or more appointments are missed within a 12-month period Altahir Behavioral Health will discontinue medication management services.
- You are subject to charge if a prescription is lost or misplaced.
- Altahir Behavioral Health will not release a prescription without proper identification of a party listed on the Consent to Disclose Information Form.
- Follow up care is very important to both you and your doctor. Being compliant with your appointments enables us to refill your medications in a timely manner. If appointments are not kept according to your doctors' recommendations, no refills can be issued until you are seen for your next follow up appointment.
- If you would like to keep a copy of our Office Policies, please ask receptionist. We encourage you to keep a copy for your records.

In signing below, I am stating that I fully understand the Office Policies stated above and that if I have any question they were explained to my satisfaction.

Patient Name: Patient Signature:

Parent/Legal Guardian:

Date:

ATTENTION PATIENTS

EFFECTIVE IMMEDIATELY

ALTAHIR BEHAVIORAL HEALTH PROVIDERS WILL NO LONGER BE PRESCRIBING ANY

BENZODIAZEPINES

A list of benzodiazepine drugs include:

KLONOPIN (CLONAZEPAM)

XANAX (ALPRAZOLAM)

LIBRIUM (CHLORDIAZEPOXIDE)

VALIUM (DIAZEPAM)

ATIVAN (LORAZEEPAM

DORAL (QUAZEPAM)

HALCION (TRIAZOLAM)

ROHYPNOL (FLUITRAZEPAM)

Sign: **Date:**

Altahir Behavioral Health PLC

Informed Consent to Treatment
Patient's Rights and Responsibilities.

I understand that treatment offers no guarantees. By working with my provider, I have the opportunity to get help with the problems and concerns that I bring. I understand that I will benefit of treatment in proportion to the effort, dedication and willingness to participate in session, I will not limit myself to only in office efforts. I understand that the effectiveness of treatment can be limited.

I agree to cooperate with my provider or discuss with them why I am unable to. I agree to ask any questions I may have regarding my treatment and the goals that I along with my provider have set to reach peak wellness.

I understand that treatment will end if I am no longer willing to accept the treatment given by my provider. I also understand that I am able to at any point in time end the doctor patient relationship if I an unsatisfied with the level of care and or effectiveness.

Patient Name:

_____

Guardian Name:

_____

Patient Signature:

_____

Guardian Signature:

_____

Consent to Release/Disclose Health Information

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

I hear by request that health information be discussed with and disclosed to the family member, school officials, or friends listed below. The identified below are involved in my/my child's care, and agree that the provider listed above may share such information as the provider deems relevant to such individual's involvement, including appointment times, required care, prescription release and diagnosis. I understand that I have the right to revoke this consent, release by delivering written notice to the provider.

Please list individual's legal name and relationship to you/your child.

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please note that we will not make appointments, release information, or prescriptions to any persons not named on this form.

_____

Printed name of patient/parent/legal guardian

_____ _____

Signature of patient/parent/legal guardian **Date**