Patient Information:

First Name M.I. Last Name Social Security # Birthdate Age Sex Marital Status

Street Address City State Zip

Employer or School Occupation Employer Address

(_____)_____ (_____)_____
Home Phone Business Phone

Primary Insurance Information: (Subscriber's name)

First Name M.I. Last Name Social Security # Relationship to Patient

Street Address City State Zip Birthdate

Employer Occup ation Employer Address

( ) ( )
Home Phone Business Phone Marital Status

Secondary Insurance Information: (Subscriber's Name)

First Name M.I. Last Name Social Security # Relationship to Patient

Street Address City State Zip Birthdate

Employer Occupation Emplo yer Address

(____)_____ (____)_____
Home Phone Business Phone Marital Status

Complete if Patient is Under 18 Years of Age:

Parents are: Married_____, Separated_____, Divorced_____, Single_____

Who is the legal guardian of the pati ent?_____

Emergency contact : _____

Address_____ Home Phon e_____ Work Phone_____

Optimum Behavioral Health
Edward Amos, Ph.D.
Memphis, TN 38119

Insurance Agreement

Please choose one option:

_____ I choose to use my insurance as partial payment for psychological services.

Patient's Name: _____
Name of Policy Holder: _____

Primary Insurance Company: _____
Insured ID Number: _____
Insured Group umber/Name: _____
Address of Insurance Company: _____
Phone Number of Insurance Company: _____

Secondary Insurance Company: _____
Name of Policy Holder: _____
Insured ID Number: _____
Insured Group Number: _____
Address of Insurance Company: _____
Phone Number: _____

My signature below indicates that I have been informed of the policies and payment arrangements of Optimum Behavioral Health, Inc. I understand that I may request clarification or additional information about the policies and payment arrangements, and may request a copy of this document at any time.

I authorize payment of my medical benefits to Optimum Behavioral Health, Inc. for partial payment for professional services provided. In order to obtain insurance reimbursement, I authorize the release of any information pertinent to my case to my insurance company, managed care agent, or adjuster. A photocopy of this assignment is considered as effective and valid as the original.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

_____ I choose to pay in full for psychological services and I do <u>not</u> wish for my insurance company to be billed.

_____ _____
Patient/Guardian Signature Date

_____ _____
Witness Date

OPTIMUM BEHAVIORAL HEALTH, INC.

Client Rights

Confidentiality: Your communication with your psychologist is confidential, which means that it is private and your psychologist cannot share the information with anyone outside this office without your signed consent. There are some exceptions, for example, in the case of life threatening emergencies or when there is a court order requiring records of psychotherapy.

- Dangerous behaviors (including serious thoughts of hurting yourself or another person, or information about possible child/elder abuse) are not confidential. Your psychologist will report dangerous behaviors to the appropriate authorities to keep you and other people safe.
- If you were referred to counseling by a Court Order, information about your treatment is not confidential and can be related to the Court without your permission.
- If you are involved in legal actions of any kind and you inform the Court that you have received mental health services, you may be waiving your right to keep your records confidential. You may wish to consult your attorney before you disclose to the Court that you have received mental health services.
- Most third party payers for mental health benefits (e.g. insurance companies, Medicare, Medicaid, employee assistance programs) require psychologists to provide information regarding the patient's symptoms, diagnosis, place of service, dates of service, a treatment plan, and other related information. When you authorize your insurance company to pay for your psychotherapy, you are authorizing your psychologist to provide required information to your insurance company.

Informed Consent: You have the right to ask your psychologist for an explanation of your condition and your treatment. You have the right to agree to psychological treatment, and you also have the right to refuse treatment. You have the right to consent to release of records if you want someone else to be informed about the psychological services you receive, and you have the right to refuse to release records if you do not want someone else to know about psychological services you receive.

Other Information and Options: You may ask your psychologist for information about his/her training and credentials. You have the right to know about other mental health treatment options, regardless of their cost or availability. Further information about state provisions for your rights and responsibilities may be obtained from the Tennessee Board of Examiners in Psychology (615.367.6291) and the Mississippi Board of Examiners in Psychology (601.353.8871).

My signature below indicates that I have been informed of my rights and information about policies and fees and that I understand this information. It is my responsibility to ask my psychologist for further explanation of any of the above information that I have not understood.

_____ _____

Patient Signature Date

_____ _____

Psychologist Signature Date

OPTIMUM BEHAVIORAL HEALTH, INC.
MEMPHIS, TENNESSEE
OLIVE BRANCH, MISSISSIPPI

Authorization for Therapist to Collaborate with Patient's Physicians

I, _____, authorize **Optimum Behavioral Health, Inc** . to provi de my physician,

Physician's name: _____ _____

Office location:_____ _____

Phone number:_____ _____

Information about my symptoms, my diagnosis, and the course of my treatment.

I also authorize my physician _____
To provide Optimum Behavioral Health, Inc., information/records of my medical conditions and treatments.

This authorization will expire 90 days f rom today, or at any time I choose to revoke the authorization.

_____ _____
Patient's Signature Date

_____ _____
Witness' Sig nature Date

OPTIMUM BEHAVIORAL HEALTH, INC

PLEASE UNDERSTAND:

You will be billed $50 for each missed appointment or late cancellation (cancellation less than 24 hours in advance). Your insurance company cannot be billed for this fee, and you must pay this fee prio r to any further appointment .

Would you like to be called to remind you of your appointment? Yes_____ No_____

If so, please indicate phone number(s): _____

PATIENT NOTIFICATION OF PRIVACY RIGHTS

The Health Insuran ce Portability and Accountability Act (HIPAA) have created new patient protections surrounding the use of protected health information. Commonly referred to as the "medical records privacy law", HIPAA provides patient protections related to the electronic transmissions of date ("the transaction rules"), the keeping and use of patient records ("privacy rules") and storage and access to health care records ("the security rules"). HIPAA applies to all heath care providers, including this office, and provider s and health care agencies across the country are required to provide patients with a notification of their privacy rights as it relates to health care records . You may have already received similar notices from other health care providers or seen such a n otice in offices and hospitals.

As you might gather, the HIPAA regulations are quite detailed and difficult to understand for those without formal legal training. The Patient Notification of Privacy Rights is Optimum Behavioral Health's attempt to inform you of your rights in a simple yet comprehensive fashion. Please read the document offered to you, as it is important to know what patient protections HIPAA affords all of us . In this office, confidentiality and privacy are central to treatment, and we will do all we can to protect the privacy of your records. If you have any questions, please do not hesitate to bring them up with the psychologist.

By law, we are required to secure your signature indicating you have had opportunity to review the Patien t Notification of Privacy Rights document. You are entitled to have a copy of this document at any time, either on paper or electronically sent to an email address of your choosing.

I, _____, understand and have b een provided a copy of Optimum Behavioral Health's Patient Notification of Privacy Rights Document which provides a detailed description of the potential uses and disclosures of my protected health information as well as my rights on these matters. I unde rstand I have a right to a paper or electronic copy of this document by requesting such at any time.

_____

Patient Signature or Parent if Patient is Minor

OPTIMUM BEHAVIORAL HEALTH, INC.

MEDICAL REVIEW FORM

Name: _____ Date: _____

Family Physician: _____ Height: _____

Last Examination Date: _____ Weight: _____

Have you ever been treated for or been diagnosed with one of the following? (Please circle applicable items.)

A. High blood pressure, anemia or any other blood disorder.

B. Chest pains, shortness of breath, heart attack, any history of cardiac illness.

C. Diabetes or other endocrine disorders.

D. Any disorder of the kidney, bladder, prostate, breast or reproductive organs.

E. Ulcer, chronic indigestion, intestinal bleeding, hepatitis, colitis, or diarrhea.

F. Asthma, tuberculosis, bronchitis, emphysema, or other disorders of the lungs.

G. Fainting, convulsions, tension or migraine headaches, paralysis, epilepsy, memory loss or confusion, or any disorders of the brain or nervous system.

H. Arthritis, gout, back pain or other disorders of the muscles, bones or joints.

I. Do you use any tobacco products? How often? _____

J. Do you use any type of alcohol products? How often? _____

Have you noticed any recent changes in your vision, hearing, coordination, balance, strength, speech, memory or thinking, changes in energy, sleeping, eating, elimination, menstrual cycle, sexual activity?

Please list any psychiatric, psychological, or mental health treatment history

_____

_____

Please list all medications you are taking:

_____

_____

Please list any medication, food, pollens, or other substances you are allergic to:

_____