North Fulton Behavioral Health Center

Patient Information

Last Name: ____________________ First: ________________ Middle: ___________

Home Address: _______________________________________ Apt. #: __________

City: ____________________________ State: ________ Zip Code: ______________

Home Phone: ____________________ Mobile Phone: ________________________

Other Phone: _____________________

Please circle which phone number we may use for appointment reminder calls:

Home / Mobile / Other

Please indicate by circling either "Yes" or "No" if we may leave a message for you at that number: Yes / No

Employer: __________________________ Work Phone: ______________________

Emergency Contact Information:

Name: ______________________________ Phone: __________________________

Relationship to patient: ______________________________

____ ________________________

Signature of Patient or Guardian Date

North Fulton Behavioral Health Center
555 Sun Valley Drive Suite B1
Roswell, GA 30076

Patient Identification:
Last Name _________________________ First ____________________ Middle _____________
Home Address ____ Apt. # _____________
City _________________________ State _______ Zip Code ___________
Date of Birth ___________________ Social Security Number ____________________________
Phone Numbers: Home ________________ Work _________________ Mobile _______________

Employment:
Employer ___________________________Address _____________________________________
City _______________________ State ________ Zip Code ______________

Emergency Contact Information:
Name _____________________________________ Relationship to Patient _________________
Address ____ Phone Number __________________

Financial Responsibility:
Last Name ____________________________________ First ______________________________
Address ____
City _____________________________________ State ________ Zip Code __________________
Home Phone _______________________________ Business Phone _______________________

Insurance Information – Proof of insurance must be provided at the time of the visit:
Name of Insurance Company ____
Claims Address ____
Policy ID Number ________________________________ Group Number ____________________
Effective Date __________________
Policy Holder's Information (if not patient):
Name ____________________________________ Relationship to Patient ___________________
Social Security Number __________________________ Date of Birth _______________________

If you have insurance that requires preauthorization you must notify office staff before each visit. It is your responsibility to ensure that your visits are authorized so that they may be covered by your insurance.

I hereby authorize any information needed to be released to my insurance company for the sole purpose of authorizing and processing my claims. I understand that I am fully responsible for my bill and will assume any charges not paid by my insurance company.

____ ______________________________
Signature of Patient of Guardian **Date**

North Fulton Behavioral Health Center
555 Sun Valley Drive, Suite B1, Roswell, GA 30076

LAST NAME ____________________________ **FIRST NAME** _________________________

Briefly describe the reason for your visit:

____
____
____
____
____
____
____
____

Please list any doctor and/or therapist from whom you are currently receiving treatment and provide their contact information:

____
____
____

Practice Name ____
Address ____
Office Phone Number _____________________ Office Fax Number ______________________

If you have you ever been hospitalized for any psychiatric conditions please list the dates of admission and names of facilities:

____
____
____

Please list all prescription and over-the-counter medications you are currently taking:

____
____
____
____

Please list the names of all persons you give NFBHC permission to release to either verbal or written information regarding your being a patient and your treatment (for example, spouse, partner or other family members, primary care physician or psychotherapist):

____
____
____

Signature: ____________________________________ **Date:** ___________________________
(Patient or Patient's Guardian)

North Fulton Behavioral Health Center Policies and Procedures

Please read the following explanations of some important policies and procedures for you to be aware of, and please signify that you understand each one by putting your initials after each them, and please sign the bottom of the form, indicating that as a patient of North Fulton Behavioral Health Center you agree to abide by these policies and procedures.

Patients are asked to keep NFBHC informed or any changes in information such as insurance, address, or phone number for appointment or reminder calls; you will be responsible for charges for missed appointments, or fees for refilling insurance if we have not been informed of changes in your information. _______ (Initial)

Appointments must be cancelled with at least 24 hours notice to avoid a charge of $125 which is the fee regardless of your insurance payment amount. NFBHC extends every effort to make reminder calls to all patients 1-2 business days prior to their appointment as a courtesy; however, a missed appointment fee will be charged regardless of whether or not a patient has received their reminder calls. _______ (Initial)

Prescription refill requests, whether by phone from you or by phone, fax, or electronically from your pharmacy may require 1-2 days for processing; please take this into account when requesting refills. Furthermore, you may not receive a call from NFBHC that your prescription has already been sent to your pharmacy, so please call your pharmacy first. _______ (Initial)

There will be a $25 fee for refills requested when a patient has lost their prescription or medication, or if a patient's insurance company requires a prior authorization or appeal before they will allow the prescription to be filled by your pharmacist. _______ (Initial)

If you require additional documentation for outside agencies, such as disability insurance claims, there will be a charge for preparation of these reports, correspondence, or forwarding of your medical records. _______ (Initial)

I have read, I understand and I agree to abide by the above policies and procedures.

Patient's signature:_______________________________ Date: ________________

North Fulton Behavioral Health Center
Consent To Treatment Form

I ______________________ give consent to North Fulton Behavioral Health Center consent to release confidential health care information to my insurance company for the purpose of providing needed health care treatment, obtaining authorizations, and to obtain payment for health care services.

CONDITIONS:

The patient understands that his/her health care information is to be used for treatment, payment, or health care operations.

The patient understands that his/her health care information may be disclosed to other health care providers for the purposes of treatment, payment or health care operations.

North Fulton Behavioral Health Center reserves the right to honor or dismiss the patient's request to limit the use of patient's health care information to obtain payment, authorizations, or provided needed health care treatment.

The consent is between North Fulton Behavioral Health Center and the above mentioned patient.

SIGNATURES:

Patient:
____Date:________________

NFBHC
Representative:_____________________________Date:________________

COMMUNICATING WITH YOU; CONSENT TO CONTACT BY ELECTRONIC AND OTHER MEANS ("WE," "OUR," AND "US" MEANS North Fulton Behavioral Health Center):

We will use the telephone number(s) and email address(es) that you provide to us to communicate with you in person or electronically, including staff-dialed and automated telephone calls, text messages and email communications. You can opt out of any or all of these communication methods at any time by contacting us or by choosing opt-out options that are included in the messages you receive from us. We may make multiple attempts to deliver a message and we may use more than one delivery method if we are not confident that you have received the message. Our communication with you will include messages such as appointment reminders and confirmations, annual exam due messages, wellness checkups, prescription messages, emergency closing announcements, instructions, directions, communication about your financial account, post-care follow up, satisfaction surveys, preventive care messaging, and other messages closely related to our mission to provide the best possible healthcare to you.