

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 or 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 of 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 \$115 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: _____