Heritage Behavioral Health Consultants

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Welcome to the practice of Heritage Behavioral Health Consultants. We are pleased you have chosen our office and will assure you that we are working with you in a caring and professional manner. Please take a few moments to read our office policies and do not hesitate to ask any questions you may have. These policies are further detailed in the Notice of Privacy Practices following this form.

OFFICE HOURS

Regular support staff hours are from 8:00am to 5:00pm Monday through Friday. Each clinician sets his or her own schedule and will work with you to schedule a mutually agreeable time.

SESSIONS

Full sessions are 45 minutes and half sessions are 25 minutes long. In order to ensure that your time is respected and waiting time does not interrupt your schedule or ours, every effort is made to start and stop on time. Extended sessions can be arranged when necessary, that will include an additional fee.

CANCELLATIONS

There is no charge for missed appointments **IF APPOINTMENT IS CANCELLED AT LEAST 24 HOURS IN ADVANCE**. If the appointment is for Monday, the cancellation may be made-by leaving a message with the answering service. **WE DO CHARGE FOR APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE.**

EMERGENCY SERVICES

As a general practice, emergency consultation is provided 24 hours each day, seven days a week. In the event you are unable to reach your therapist please call 911, the Crisis Hotline (713-HOTLINE), or go to the nearest emergency room. Your clinician will discuss specific emergency procedures with you in detail. You may reach us at (713)365-9015. If we do not answer in 30 minutes, please call a second time and let the service know this is an emergency. If the consultation requires more than 15 minutes, you may be billed for time.

NOTICE OF PRIVACY PROCEDURES

In accordance with the Health Insurance Portability and Accountability Act (HIPPA), Heritage Behavioral Health Consultants is required to: 1) maintain the privacy of your health information, 2) provide you with a Notice to our legal duties and privacy practices with respect to the information that we collect and maintain on you, 3) abide by the terms of the Notice, 4) notify you if we are unable to agree to a requested restriction, 5)

accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations. Please refer to our **Notice of Privacy Practices** for detailed information.

FEES

Payment is due at the time of service rendered in the form of cash, check or credit card. We do not file insurance in this office; however for those clients that belong to an insurance company that wish to file, we will give you an itemized statement so that you can file it with your insurance company in order to have them reimburse you directly.

It is the policy of this practice to turn delinquent accounts over to collection after 90 days. If it becomes necessary to do this, there will be an additional 10% charge to the outstanding balance.

PERSONAL RELATIONSHIPS

Our goal is that we will develop a positive, rewarding relationship. At this time, please take a few minutes to fill out the enclosed information so that we may better help you achieve your goals.

I HAVE READ AND FULLY UNDERSTAND THE **PATIENT SERVICES AGREEMENT** AND AGREE TO ITS TERMS.

Patient's Full Name (please print): _____

Signature: _____ Date: _____

I HAVE RECEIVED A **NOTICE OF PRIVACY PRACTICES** AND AGREE TO ITS TERMS.

Patient Signature: _____ Date: _____

Clinician Signature: _____ Date: _____

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Adult Patient Information

Date: _____ Clinician Name: _____

Patient's Name: _____

D.O.B.:_____ Sex: M_____ F_____

Patient's Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone: _____

Employer: _____ Occupation: _____

Business Address: _____

Wk Phone:_____ Email: _____

Emergency contact:_____ Phone: _____

Referred by: _____

Would you like an invoice after every visit? ☐Yes ☐No

Is it alright to leave a voicemail on your answering device? ☐Yes ☐No

At which phone number? ☐ Home ☐ Cell ☐ Work

Would you like to keep your credit card info on file for ease of payment: Yes No

Card Holder Name: _____

Credit Card No.:_____

Exp. Date: _____ CVV Code: _____ (3 digit code on back of card)

Credit Card Billing Address: _____

Signature: _____