PATIENT REGISTRATION
PLEASE SIGN BOTTOM LINE

Patient's Name: First _____ M.I. _____ Last _____

Street/Billing Address: _____

City: _____ State: _____ Zip: _____ - _____

Main Phone: (_____) _____ Alternate Phone: (_____) _____

SSN: _____ Email Address: _____

Birth Date: _____ Gender: M / F Marital Status: Single / Married / Divorced / Widowed

Responsible Party if Under Age of 18: _____ Relationship to Patient: _____

Referring Physician: _____ Primary Care Physician: _____

Employer's Name: _____ Work Phone: (_____) _____

Emergency Contact: _____ (_____) _____
Name Relationship

Address: _____
Street City State Zip Code

RESPONSIBLE PARTY / INSURANCE GUARANTOR

Name: First_____ M.I. _____ Last _____

Address: _____
Street City State Zip Code

Main Phone: (_____) _____ Email: _____

SSN: _____ Date of Birth: _____ Relationship to Patient: _____

Main Phone: (_____) _____ Alternate Phone: (_____) _____

Employer: _____ Telephone: (_____) _____

INSURANCE INFORMATION

PRIMARY: Insurance Company & ID #: _____

SECONDARY Insurance Company & ID #: _____

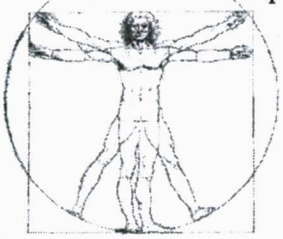
ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include all major benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Arias Neuropsychology & Behavioral Medicine, P.C. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Arias Neuropsychology and Behavioral Medicine, PC, to release to the insurance companies above or to any other payer (i.e. Attorney, Workman's Compensation Company, etc.), to myself, to my PCP, and to my referring physician, any information necessary for treatment or payment. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

Signature: _____ Date: _____

Responsible Party: _____ Date: _____

Arias Neuropsychology and Behavioral Medicine, PC



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CONSENT AND OFFICE POLICIES

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION: By signing this form, you are granting consent to Arias Neuropsychology and Behavioral Medicine, PC to use and disclose your protected health information for the purposes of treatment, payment, and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full. Our Notice of Privacy Practices is subject to change. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.
I acknowledge that I have been offered a copy of Arias Neuropsychology & Behavioral Medicine, P.C. Notice of Privacy Practice Policy, which describes how my health insurance information may be used or disclosed.

NO SHOW AND CANCELLATION POLICY: If you arrive more than ten minutes past your scheduled appointment, you may be considered a no show. We ask for cancellations to occur no less than 24 business hours prior to your appointment, unless there is an unforeseen emergency. Three late cancellations or no shows will result in a release from the clinic and will require a new referral. This policy also applies for any other appointments in this clinic, with any provider. Another outpatient doctor's appointment, lack of transportation, or work conflict is *not* considered an emergency. If an emergency does occur that necessitates canceling the appointment, it is your responsibility to call as soon as possible to let us know. This will give us an opportunity to fill the appointment. **If you no-show for an appointment or cancel less than 24 business hours before an appointment *without* an unforeseen emergency, you will be charged $50 for *each* hour that was scheduled for you.**

LIMITS OF CONFIDENTIALITY AND CONSENT TO TREAT: Information obtained during assessments and psychotherapy is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law. A report is also provided to the referral source, typically for the purpose of treatment, unless you specifically indicate, in writing, you do not wish this to occur.
I agree and consent to participate in behavioral health care services offered and provided at/by Arias Neuropsychology and Behavioral Medicine, PC, to include all its behavioral health care providers. I understand that I am consenting and agreeing only to those services within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____
Print Patient Name Date of Birth

_____ _____
Patient/Responsible Party Signature Date

Authorization to Disclose Health Information to Primary Care Physician

Communication between your psychotherapist and your primary care physician (PCP) is important to make sure all care is complete, comprehensive, and well coordinated. This form allows you therapist to share valuable information with you PCP. No information will be released without your signed authorization. Once completed and signed, please give this form to your behavioral health provider.

I hereby authorize the disclosure of health information about the individual named below.
I am: _____the individual named above
_____a representative because the patient is a minor, incapacitated, or deceased

Patient Information:

Last Name:	First Name:	Middle Initial:
Member ID:	Date of Birth:	Phone Number:

☐ **I give Arias Neuropsychology and Behavioral Medicine, PC permission to disclose information to the following PCP:**

Name:	Phone Number: Fax Number:
Street Address:	City, State, Zip

☐ **I DO NOT give Arias Neuropsychology and Behavioral Medicine, PC permission to contact my PCP**

Information to be disclosed about the individual includes any applicable mental health and/or substance abuse information, including diagnosis, treatment plan, progress, and medication(s) if necessary. This authorization shall expire one year from the date of signature below.

Important Rights and Other Statements You Should Know

- You can revoke this authorization at any time by writing Arias Neuropsychology. If you revoke this authorization, it will not apply to information that has already been used or disclosed.
- The information disclosed based on this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy laws. Not all persons or entities have to follow these laws.
- You do not need to sign this form in order to obtain enrollment, eligibility, payment, or treatment for services.
- This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
- You have the right to a copy of this authorization once you have signed it. Please keep a copy for your records.

_____ I declined a copy of the Nebraska Power of Attorney for Health Care paperwork at Arias Neuropsychology and Behavioral Medicine. A copy is available if I change my mind.

Signature: _____ Date: _____

Signature of Guardian (if applicable): _____ Date: _____

Relationship to Patient: _____

Advance Directives

Power of Attorney for Health Care

Nebraska's Health Care and Treatment Decisions statute allows you to appoint an agent (called an "Attorney in fact") to make health care decisions for you if you become incompetent to make those decisions yourself. "Health care" may include mental health care. A recommended form for this purpose is called a Power of Attorney for Health Care.

An Advance Directive or Power of Attorney for Healthcare is a legal document that talks about how you want to be treated if you are not able to speak for yourself – for example, if you become very ill, or if you are put in a hospital without your permission.

You can use an Advance Directive – Power of Attorney for Health Care to:

- Tell a doctor, hospital or judge what types of confinement and treatment you do or do not want.
- Name a friend or family member who can make mental health care decisions for you if you are not able to make them for yourself.

Additional information is available from the National Resource Center on Psychiatric Advance Directives: http://www.nrc-pad.org

Once your Power of Attorney for Health care form is ready, you should give copies and explain your choices to:

- Your Doctor
- The person you have appointed to make mental health care decisions for you.
- Your family
- Anyone else who might be involved in your care

My signature below shows that I have been informed of my rights to appoint an agent, and that I understand this information.

_____ _____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form and a Nebraska Power of Attorney for Health Care form.

_____ _____

Provider Signature Date

_____

Check if Member Refused

MAGELLAN HEALTH SERVICES
MEMBERS' RIGHTS AND RESPONSIBILITIES STATEMENT

Statement of Members' Rights

Members have the right to:

- Be treated with dignity and respect.
- Be treated fairly, regardless of their race, religion, gender, ethnicity, age, disability, or source of payment.
- Have their treatment and other member information kept confidential. Only where permitted by law may records be released without the member's permission.
- Easily access care in a timely fashion.
- Know about their treatment choices. This is regardless of cost or coverage by their benefit plan.
- Share in developing their plan of care.
- Receive information in a language they can understand.
- Receive a clear explanation of their condition and treatment options.
- Receive information about Magellan, its providers, programs, services and role in the treatment process.
- Receive information about clinical guidelines used in providing and managing their care.
- Ask their provider about their work history and training.
- Give input on the Members' Rights and Responsibilities policy.
- Know about advocacy and community groups and prevention services.
- If asked, Magellan will act on the member's behalf as an advocate.*
- Freely file a complaint or appeal and to learn how to do so.
- Know of their rights and responsibilities in the treatment process.
- Request certain preferences in a provider.
- Have provider decisions about their care made on the basis of treatment needs.
- Receive information about Magellan's staff qualifications and any organization Magellan has contracted with to provide services.*
- Decline participation or withdraw from programs and services.*
- Know which staff members are responsible for managing their services and from whom to request a change in services.*

Statement of Members' Responsibilities

Members have the responsibility to:

- Treat those giving them care with dignity and respect.
- Give providers and Magellan information that they need. This is so providers can deliver quality care and Magellan can deliver appropriate services.
- Ask questions about their care. This is to help them understand their care.
- Follow the treatment plan. The plan of care is to be agreed upon by the member and provider.
- Follow the agreed upon medication plan.
- Tell their provider and primary care physician about medication changes, including medications given to them by others.
- Keep their appointments. Members should call their provider(s) as soon they know they need to cancel visits.
- Let their provider know when the treatment plan is not working for them.
- Let their provider know about problems with paying fees.
- Report abuse and fraud.
- Openly report concerns about the quality of care they receive.
- Let Magellan and their provider know if they decide to withdraw from the program.*

* This standard is required for our *Condition Care Management* (CCM) products.

My signature below shows that I have been informed of my rights and responsibilities, and that I understand this information.

_____

Member Signature Date

The signature below shows that I have explained this statement to the patient. I have offered the member a copy of this form.

_____

Provider Signature Date