1638 Battlefield Parkway
Fort Oglethorpe, GA 30742
P: (706) 841-0500 F: (706) 841-0502
E: info@vitalishealth.org

New Patient Information:

Name: _____ **Contact Phone:** _____
Date of Birth: _____ **Alternate Phone:** _____
Mailing Address: _____ **Primary Care Doctor:** _____
_____ **Referring Provider:** _____

Mental Health Concerns and History:

List symptoms of concern: _____

_____

_____

What is the primary goal for this visit: _____

_____

_____

Check services you are interested in:

□ Clarification of Diagnosis □ Medication Treatment □ Therapy / Behavior Training

What mental health diagnosis have you been given or do you suspect? _____

List any clinics or mental health centers where treatment has been provided:

Clinic or Center	Dates of Service

Facility	Reason for Hospitalization	Dates

Medications, Allergies, Surgeries:

List all current medications and dosages:

Medication	Dose

Pharmacy: _____ Location: _____

Allergies (medication, food, seasonal): _____

List any surgeries or hospitalizations:

Facility	Reason for Hospitalization	Dates

Birth and Developmental History: (For Pediatric Patients only)

Mother's age at birth: _____ **Child's Birth Weight:** _____ **Full-term Pregnancy?** _____

Was mother exposed to toxins during pregnancy (medications, tobacco, alcohol, illegal drugs)? _____

If yes, list here: _____

Has your child ever had a psychological or IQ testing? _____

At what age was your child able to do the following:

First Walk: _____ Said first words: _____

Toilet trained: _____ Used 2-3 word phrases with meaning: _____

Educational and Social History (For Pediatric Patients only)

Has your child ever received any special education services at school?

Does your child have an IEP (Individualized Education Plan)?

Name of Current School:

Has your child received any of the following:

☐ Behavioral Therapy ☐ Physical Therapy ☐ Occupational Therapy

Has your child had significant disciplinary actions at school (suspension, expulsions)?

Has your child had any legal problems?

Is your child interested in making and keeping friends?

Potential stress history for child:

☐ Parental divorce ☐ Domestic Violence ☐ Victim of physical abuse

☐ Parent separation / marital problems ☐ Serious illness in the family ☐ Victim of sexual abuse

☐ Arrest / convictions of family members ☐ Death in the family ☐ Victim of verbal / emotional abuse

List all biological family members and those living in the home:

Relation	Name	Age	Living in home:	Current/Highest Grade
Bio Father:			□ Y □ N	
Bio Mother:			□ Y □ N	
			□ Y □ N	
			□ Y □ N	
			□ Y □ N	
			□ Y □ N	

Family History:

Please list any biological family members who have had the following:

- Sudden death, heart rhythm problems, genetic disorders
- Autoimmune disorders (thyroid disease, Lupus, Multiple Sclerosis)
- Psychiatric conditions (anxiety, depression, schizophrenia, bipolar disorder, obsessive compulsive disorder, ADHD)
- Developmental conditions: (mental retardation, learning problems, learning disorders)
- Neurological conditions (seizures, tics)
- Drug / Alcohol problems

Name and Relationship to child	Description of conditions from the list of categories shown above:

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**** IF THIS FORM IS NOT FILLED OUT COMPLETELY AND CORRECTLY, INSURANCE MAY NOT PAY ****

If incomplete or incorrect information is provided, Parent / Guardian is responsible for payment

Patient Information:

Name: _____
Last Name First Name MI

Mailing Address: _____
Street City/State / ZIP

Email Address: _____ **Race / Ethnicity:** _____

Date of Birth: _____ **SSN:** _____

Contact Phone: _____

Emergency Contact: _____
Name Phone

Billing Information (if different than above):

Name: _____
Last Name First Name MI

Relationship to Patient: _____

Mailing Address: _____
Street City/State / ZIP

Email Address: _____

Primary Phone: _____ **Employer:** _____

Alternate Phone: _____ **SSN:** _____

Primary Insurance Coverage:

Insurance: _____

Policy Holder: _____
Last Name First Name MI

Date of Policy Holder (MM/DD/YYYY): _____ **Relationship to Patient:** _____

Policy Holder Info: □ Same as Parent / Guardian Above (if not, please complete the following info)

Mailing Address: _____
Street City/State / ZIP

Phone: _____ **Employer:** _____

Alternate Phone: _____ **SSN:** _____

Secondary Insurance Coverage:

Insurance: _____

Policy Holder: _____
Last Name First Name MI

Date of Policy Holder (MM/DD/YYYY): _____ **Relationship to Patient:** _____

Policy Holder Info: □ Same as Parent / Guardian Above (if not, please complete the following info)

Mailing Address: _____
Street City/State / ZIP

Phone: _____ **Employer:** _____

Alternate Phone: _____ **SSN:** _____

_____

Signature of Parent or Guardian: **Date**

Patient Rights and Responsibilities

YOU HAVE THE RIGHT:

- To be treated with consideration, respect, and full recognition of your dignity and individuality regardless of your state of mind or condition.
- To be provided with treatment without regard to race, color, birthplace, language, gender, age, religion.
- To complete privacy of your medical and financial information.
- To be informed of treatment options and or alternative treatment methods regardless of cost or benefit.
- To be informed of the risks, benefits, and consequences of treatment or non-treatment.
- To be informed of the side effects of your medication or proposed medication.
- To participate in the development of your individual treatment plan.
- To participate in all decision making regarding your behavioral health care, including discharge or aftercare.
- To be provided quality treatment by competent staff members.
- To refuse to participate partially or fully in treatment or therapeutic activities.
- To be provided treatment in the least restrictive setting that is clinically appropriate, feasible and available.
- To be provided with a copy of your basic rights and responsibilities and to have all questions answered.
- To voice complaints about your services.
- To be given information about the Declaration of Mental Health Treatment, or to designate a person to make decisions using a Durable Power of Attorney for Healthcare.
- To make recommendations about your rights and responsibilities.
- To be provided with a list of available advocacy services and contact information when requested.
- To ask for and receive information about your medical records, review of records, make corrections to your medical records and to receive copies of your medical records.

YOU ARE RESPONSIBLE:

- To provide accurate information to your provider(s).
- To treat healthcare provider / staff with respect and dignity.
- To cancel appointments your are unable to keep.
- To follow the instructions and guidelines given by providers.
- To participate, to the degree possible, in understanding your behavioral health problems and to develop mutually agreed upon treatment goals.

I have read the Rights and Responsibilities and all my questions have been answered to my satisfaction.

_____ _____

Signature of Patient/Guardian **Date**

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Patient Consent Form

I, the undersigned, hereby consent to the following:

- Administration and performance of all treatments.
- Performance of such procedures as may be deemed necessary or advisable in the treatment of this patient.
- Use of prescribed medication.
- Performance of diagnostic procedures / tests.
- I fully understand that this is given in advance of any specific diagnosis or treatment.
- I intend this consent to be continuing in nature even after a specific diagnosis has been made.
- The consent will remain in full force until revoked in writing.
- I understand that Vitalis Behavioral Health includes consent at satellite offices under common ownership.
- I, the undersigned, acknowledge that Vitalis Behavioral Health will use and disclose my information for the purposes of treatment, payment and healthcare operations.
- Treatment includes, but is not limited to: the administration and performance of all treatments, the administration of any needed anesthetics, the use of prescribed medication, the performance of such procedures as may be necessary or advisable in the treatment of this patient, such as diagnostic procedures, the taking and utilization of cultures and of other medically accepted laboratory tests, all of which the attending physician or their assigned designees, may be considered medically necessary or advisable.
- Payment includes but is not limited to the authorization of payment directly to Vitalis Behavioral Health of benefits otherwise payable to me. I hear by acknowledge the release of my medical records to third party insurers or authorized persons to whom disclosure is necessary to establish or collect a fee for the services provided, such as billing and collection services, Insurance payers, auto incident insurers, or for work related injury, to my employer or designee. **I understand that I am financially responsible for charges not covered.** In acknowledge that patient records may be stored electronically and made available through computer networks. I hereby consent for billing/collection to call by phone.
- Healthcare operations include but are not limited to: release of my medical information to any of my physicians and their offices, or insurance companies participating in my care or treatment and the quality of care.
- I fully understand that this is given advance of any specific diagnosis or treatment. I intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. This consent specifically includes release of medical information concerning drug-related conditions alcoholism, physiological conditions and/or infectious diseases.
- A photocopy of this consent shall be considered as valid as the original.
- For the safety of our staff and patients, we do NOT tolerate aggressive/abusive language or behavior, threats, or violence. This behavior will result in prompt dismissal from future services at Vitalis Health.
- Medicare Patients: I authorize to release medical information about me to the Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Vitalis Behavioral Health. I acknowledge that I have been given the Vitalis Behavioral Health Notice of Privacy Practices. I understand that if I have any questions or complaints, that I should contact the Privacy Official.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its concerns.

Signature of Patient / Guardian **Date**

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Authorization to Release Healthcare Information

Patient Information (PLEASE PRINT):

Name: _____ DOB: _____

I request and authorize Vitalis Behavioral Health and Providers to release and/or obtain health care information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone: _____ Fax: _____

The request and authorization apply to:

- ☐ Coordination
- ☐ Continuity of Care
- ☐ Legal Purposes
- ☐ Other: _____

_____

All information available may be released including psychological testing, lab testing, and any other reports, except as listed:

_____

_____

_____

_____ _____

Signature of Patient / Guardian **Date**

_____

Printed Name

Relationship to Patient: ☐ Self ☐ Parent or Legal Guardian

This authorization is valid for one year from date signed, unless revoked before that time

** FORM MUST BE FILLED OUT COMPLETELY **

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Authorization and Informed Consent

_____ It is your obligation to stay current with your bill. Payment is due at the time of services. Future appointments will not be scheduled until your account is current. Please discuss any problems you have with making appointments or any changes in financial situation.

_____ It is your responsibility to notify Vitalis Health 24 hours in advance if you are unable to keep your scheduled appointment. If you do not notify, you may be billed for that session. Insurance carriers will not cover missed appointments, therefore, you will be responsible.

_____ If insurance coverage is available, we will file for insurance reimbursement. This service is a courtesy we extend to our patients, not a requirement. Please provide the necessary information. Failure to do so will require full payment from guarantor on the account. You are also responsible for any deductibles or co-payments at the time of service.

_____ **I understand that I am financially responsible for the deductible amount, co-payments, co-insurance amounts, non-covered charges and any and all balances not covered** under a contractual write-off agreement between Vitalis Behavioral Health and my third-party payer. My carrier's failure to pay does not release me from the responsibility. I also agree that should this account be turned over to collection I will be responsible for all costs associated with debt collection, including attorney fees and court costs. I acknowledge the receipt of Vitalis Behavioral Health Notice of Privacy Practices.

_____ I understand that it is my responsibility to obtain a referral from my primary care physician, if required, and contact my insurance prior to my visit to receive information about the pre-authorization. Insurance companies will not backdate an authorization; therefore, if this step is omitted or forgotten, your are held liable.

_____ If my insurance plan has changed, it is my responsibility to notify the office prior to my appointment. In instances where my plan required pre-authorizations or a referral from my primary care physician, it is my responsibility to notify the physician's office. If I do not give proper notification prior to the visit, and insurance denies a claim, I understand the bill is my obligation. This applies to all insurances.

_____ We cannot resubmit claims for dates incurred before notification of an insurance change due to guidelines for timely filing.

_____ 2 or more no shows or late cancellation and/or rescheduled appointments may result in being discharged from our practice.

Signature of Patient / Guardian **Date**

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Authorization and Informed Consent

If you are not the legal guardian, a signed consent form is required from the custodial parent. If you are divorced, a copy of the divorce papers stating your legal guardianship required prior to treatment.

I agree and consent to participate in the behavioral healthcare services offered and provided by Vitalis Behavioral Health. I understand that I am consenting and agreeing only to those services that my provider qualified within the scope of the provider's license, certification, and training.

I authorize Vitalis Behavioral Health to release to my insurance company, managed care organization, state agency(ies), Health Care Financing Administration, third party administrators, and/or Worker's Compensation or its agents any information needed to process my claim and/or determine benefits payable to related services. I also authorize Vitalis Behavioral Health to utilize a fax machine to transmit and/or all of the above medical records pertaining to my medical or Insurance reimbursement. I acknowledge that faxing my medical records may increase the risk of accidental disclosure of medical records.

I grant permission for Vitalis Behavioral Health to release all or part of my medical records to any consulting entity that my be involved in my medical care. This includes, but is not limited to purposes of treatment, payment, and healthcare operations.

I request that payment of Midicare, Medigap, Traveler's Railroad Retirement, Managed Care Organizations, Third Party Administrators, Commercial, Worker's Compensation, Liability and/or any other insurance benefits be made on my behalf to Vitalis Behavioral Health for services furnished to me or on my behalf by that provider.

Signature of Patient / Guardian **Date**

Notice of Privacy Practices

I have had full opportunity to read and consider the contents of this Consent Form and your Notice of Privacy Practices ***. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment and healthcare

Signature of Patient / Guardian **Date**

*** A copy is available for your records at your request

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Patient Email and Text Messaging Registration Form

Vitalis Health now has the ability to provide our patients with certain types of information via emails and/or text messaging. If you wish to have the opportunity to receive email or text notifications, please complete the form below.

Vitalis Health strongly believes in protecting the privacy of our patients. When you provide this information, it is only used as a way to communicate with you. Patient names will be listed in the Please print all information neatly or legibly.

Patient Name: _____

Email Address: _____

- □ Yes, please sign me up to receive email appointment confirmations
- □ No, I do not wish to receive email appointment confirmations

Cell Phone Number: _____

- □ Yes, please sign me up to receive text messaging appointment confirmations
- □ No, I do not wish to receive text messaging appointment confirmations

*Standard Text Messaging Rates will Apply

I hereby give Vitalis Health permission to send messages to me via email and/or text messaging as a means of communication as indication by my selection above.

Print Name: _____

Signature: _____

Date: _____

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Medication Refill Policy

Making the new policy work smoothly for you:
Our new policy will be to call in appropriate requests for prescription refills within 5 business days. Please let our staff know if your request is urgent or if you are out of medication and we will attempt to provide refills sooner. Before you come to your regular appointment, please look over your medications to determine if you need any new prescriptions at your appointment. We require office visits on a regular basis for all our patients taking prescription medications. The interval will vary depending on the type of medication prescribed but is at least every 6 months. Please be sure you have enough medication to last until your next scheduled visit. Please bring all your prescription bottles with you to your appointment. This is important to make sure that you are taking the correct medications and the correct doses. We will continue to take the time to carefully review your medications and write refills at your office visit.

CONTROLLED SUBSTANCES:
•If you are on a stimulant (i.e., for attention deficit disorder) and/or a Benzodiazepine prescribed by Vitalis Behavioral Health, as an ongoing treatment, you must see your Provider every 3 months for refills. By law, stimulants can only be refilled for 1 month at a time.
•Due to additional safety concerns with controlled substances, follow up visits are mandatory every 3 months to ensure refills on those specific medications.
•If you are taking a Controlled substance, your provider will request a urine drug screen periodically. You must provide the sample in the office at that visit. If a urine specimen is not provided, your controlled medication is subject to be discontinued by the providers at Vitalis Behavioral Health.

We understand that this is a change for both you and us. We hope to work together to ensure safe and high-quality medical care!

Print Name: _____

Signature: _____

Date: _____