NORTHVIEW BEHAVIORAL HEALTH SERVICES PLLC
1321West Randol Mill Rd, Ste 105.
Arlington TX 76012
Phone: (817) 983-7600
Fax: (817) 983-7400

Welcome to Northview Behavioral Health Services PLLC

In order to best serve your medical needs, we ask that you complete the following packet in full before your arrival to our office. Although we do appreciate any efforts to save our environment, we ask that you print out the packet as it is shown to you; single sided and in black ink. When filling out the packet, please use black or blue ink. If you are unable to comply with the fore-mentioned requests, please arrive 40-45 minutes prior to your appointment so that you can complete your paperwork in a timely manner. We appreciate your cooperation with us.

Thank you,
Agather Onyango, RN, C-PMHNP

Northview Behavioral Health Services PLLC

PATIENT INFORMATION

DATE: _____

Patient's Name: _____
(First) (Middle) (Last)

How do you wish to be addressed? _____ Marital Status: _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone: (_____) _____ Work Phone: (_____) _____

Birthdate: _____ SS# _____

Employer: _____ Occupation: _____

Years Employed: _____

If Patient is a Minor (under age 18), name of parent or guardians _____

Referred By: _____
(Name) (Relationship)

RESPONSIBLE PARTY

Name: _____
(First) (Middle) (Last)

Marital Status: _____ Drivers License# _____

Address: _____
(Street) (City) (State) (Zip)

How long at this address? _____ Relationship to Patient: _____

Previous address (if less than 3 years): _____
(Street) (City) (State) (Zip)

Home Phone: _____ Work Phone: _____

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation: _____

SPOUSE INFORMATION (if applicable)

Name: _____
(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Years Employed: _____

Occupation: _____

INSURANCE INFORMATION

Primary Insured Policy Holder Name: _____
(First) (Middle) (Last)

Birthdate: _____ SS# _____

Employer: _____ Group #: _____

Insurance Company Name: _____ Member Services Phone #: _____

EMERGENCY INFORMATION

In case of emergency, call: _____

Home Phone: _____ Work Phone: _____

Relationship to patient: _____

OFFICE POLICIES

NORTHVIEW BEHAVIORAL HEALTH SERVICES
PLLC
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Arlington TX 76012
Phone: (817) 983-7600
Fax: (817) 983-7400

Office Hours and Missed Appointments

- Regular office hours are 8a-5p on Monday thru Friday.
- We require 24 hours notice if you need to cancel your appointment. There is a **$30.00** fee for follow up appointments not cancelled within 24 hours, as well as all missed follow up appointments.

Emergencies

Initial
- In case of emergency during regular business hours, contact the office as soon as possible.
- In case of an emergency after hours please go to the nearest emergency room. For urgent, but non-emergency issues, provider's number is provided via the answering system. RX refills are neither urgent nor emergent.

Fees and payment

Initial
- Payment of co-pay/deductible/co-insurance is expected at the time of your appointment.
- If you have difficulty making your payment, we will try to negotiate a payment plan with you.
- We accept cash, personal checks, MasterCard, Visa.

Insurance

- Notification of any change in your insurance must be provide ***before*** your scheduled appointment.

Initial
- If we are not provided this information in a timely manner, you will be required to pay in full.
- We accept most insurance coverage and self-pay patients.

Prescription Refills

- Medications will be handled during regular office hours.

Initial
- We do not do refills through pharmacies; you will have to contact us directly for refills.
- Please allow 48-72 hours for completion on all refill requests.
- **Controlled substance medications will NOT be refilled early regardless of whether they are lost, stolen, misused, etc**

Fee Disclosures

The following fees are incurred when you request services in addition to your regular office visit. These fees are not paid by your insurance plan. These fees include, but are not limited to:

Initial

1.	Medical records	$25.00
2.	Returned checks	$30.00
3.	Letters to employer, school, etc	$25.00 minimum
4.	Disability paperwork	$45.00 minimum
5.	Missed / cancelled follow ups without 24 hr notice	$30.00
6.	Prior authorizations required by your insurance	$25.00

Initial

Termination of the Provider – Patient Relationship

A good relationship between a provider and his or her patient is essential for quality medical care. There are times when this relationship is no longer effective and the provider finds it necessary to ask the patient to select another provider. The following are examples of situations that could make this necessary:

1. Repeated missed appointments
2. Non payment of account
3. Not following treatment recommendations
4. Misuse / abuse of prescribed medications
5. Obtaining duplicate prescriptions from multiple prescribers
6. Abusive behavior towards office staff

Initial

I have read and understand the Office Policies, and I agree to be bound by its terms.

_____ ___/___/___

PATIENT OR RESPONSIBLE PARTY (PLEASE PRINT) DATE

_____

SIGNATURE

Northview Behavioral Health Services

Consent to Treatment / Financial Responsibility / Authorization to Release Medical Information / Assignment of Benefits

I,_____, consent to treatment to be rendered to
(Patient or Responsible Party- please print)
me, my dependent, or other person designated below, and, in so doing, agree to be responsible for the payment of professional fees**. Such fees or supplemental charges, may include, but are not limited to patient copays, deductibles, non-insured services (ie., prescription renewals outside your appointment time, pharmacy authorizations, telephone/email communications, document preparation, hospital admission coordination), or services deemed by my insurance company or its agents as medically unnecessary**. **In the event that my insurance coverage cannot be verified prior to service delivery, I agree that I will be responsible for payment in full. I further agree that I am responsible, as a supplemental charge, for payment of the full billed amount of charges not paid by my insurance company or its agent within 45 days from the date of their receipt of a claim. (In accordance with The Texas Insurance Code and Department Rules, Articles 3.70-3C, Section 3A and 20 A.18B and in the Texas Administrative Code Sections 21.2801 - 21.815. An interest rate of 6% per annum may be imposed on amounts commencing on the 60th day from the date of service. A fee of $30.00 is charged for missed appointments, unless canceled 24 hours in advance. The office does not file out of network claims, but will provide a statement for you to file. Full payment for those covered by a non-network plan is due at the time of service.**

I authorize Northview Behavioral Health Services, or those acting in its behalf, to provide information regarding my medical, psychiatric, or substance abuse treatment to my insurance company or its agents for the purpose of determining benefit eligibility, for certification of care, or for claims processing purposes. This authorization is valid until revoked in writing by me or by my legal guardian. By signing this document, I represent to Northview Behavioral Health Services that I am entitled to, the benefits of any applicable health plan which I have presented. I hold Northview Behavioral Health Services and its employees harmless for any damages resultant from denial of payment, lack of certification, lack of payment for medically-recommended treatment, or failure on the part of my insurance company or its agents to maintain confidentiality in regard to my condition.

I assign any insurance benefits to Northview Behavioral Health Services PLLC.

_____ _____
Patient (Recipient of Care) (Please Print) Date

_____
Signature

_____ _____
Responsible Party (if other than patient) (Please Print) Date

Signature of Responsible Party_____

We require a credit or debit card for services not covered by insurance:

*Unpaid balances for services rendered **including those listed above**, may be charged to the following Credit or Debit Card* [ ] MC [ ] VISA [ ] AMEX [ ] DISC

Card No._____Exp. Date _____

Cardholder Name_____
(Please Print)

Cardholder Signature_____

NORTHVIEW BEHAVIORAL HEALTH SERVICES PLLC.

The "Off-Label" Use of Medication

There are times we prescribe medications, which are not labeled specifically for usage in a particular condition. This is because the U.S. Food and Drug Administration (FDA) indications for any given drug is based on their review and acceptance of studies which have been submitted to them for usage in specific diagnoses rather than symptoms. Medications treat symptoms, not diagnoses. There are times when a medication is found to be useful for one symptom or disorder, but clinical experience reveals that it is also useful in other areas. When this occurs, pharmaceutical companies occasionally conduct new medication trials and seek additional FDA approval. This pursuit of "indication for use" from the FDA is a business decision that many pharmaceutical companies decide **not** to make because of the extremely high cost of medication research and testing and the fact that the medication has already received approval for prescribing. Most pharmaceutical companies decide to rely upon doctors learning of these additional uses through articles published in medical journals, professional educational forums, and collegial networking. The usage of medications without FDA indication for a certain condition is referred to as "off-label" use.

There are special circumstances in regard to children. Most of all the medications that child psychiatrists, pediatric neurologists, and pediatricians use are used "off-label." Considering the complications of testing medication on children (a child cannot sign a waiver stating that he / she understands the risks of being involved in medication research), there are very few medications that are "approved" by the FDA for children. An example of an "off-label" use of medication with which you might be acquainted would be amoxicillin. Amoxicillin was widely used with adults and its success in treating infection led to its almost immediate embrace by pediatricians. Because it was already being used with children the manufacturer never sought an approved indication and, to this day, amoxicillin is not "approved" by the FDA for use in children although its use is nearly universal.

It is important for you to understand that the medications we recommend and prescribe have been shown to be helpful in the hands of many physicians. We want you to be informed of the possible benefits and side effects of these medications and encourage you to read all you can and ask any questions that you have. We are committed to pursuing a plan of action which leads to the lowest dosage of medication and the smallest number of medications used, consistent with optimal level of wellness. Our goal for the medication we prescribe is to treat and reverse as many symptoms as possible while pursuing additional non-medication strategies. Counseling and lifestyle changes can further add to the recovery from the presenting symptoms in the short-run. This will also enable the medication itself to work more effectively and may, in the long run, possibly negate the need for some or all of the medications originally prescribed.

Please feel free to express any concerns or questions you may have during your visit. We endeavor to provide you all the information we can in order to help you make informed decisions concerning you or your child's care.

_____ _____

SIGNATURE OF PATIENT (If 18 or older) Date

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN Date

Northview Behavioral Health Services PLLC

CONSENT TO EVALUATE and/or TREAT MINOR

(Must be completed in regard to anyone under 18 years of age)

Note: Step parent may not grant permission to evaluate or treat.
In situations of divorce, a copy of your divorce decree section pertaining to custody and consent to medical care must be provided. If you are not the parent, but are legal guardian, you must provide court documents establishing guardianship.

I,_____, as the

( ) Parent

( ) Custodial Parent (in situations of divorce)

( ) Legal Guardian

attest to have legal authority to grant consent and permission to the provider at Northview Behavioral Health Services for psychiatric evaluation and treatment of:

_____ ____/____/_____
(Print Name of Minor) Date of Birth

My name is:

_____ _____
(Print) Signature

_____/_____/_____
Date

_____
Witness

Patient/Guardian Signature Date

Authorization for Disclosure of Protected Health Information

I ,_____, authorize NBHS to disclose and provide information including copies of the following protected health information regarding (Check One)

( ) Myself

( ) My minor child over whom I am parent or guardian _____
Name of minor child

( ) My minor child of whom I am the Managing Conservator _____
Name of minor child

( ) Other party of whom I have legal guardianship. (Copy of Court Documents Required).

_____
Name of other party

to the following party:

☐ Therapist or Counselor: _____

☐ Other: _____

Protected medical information I am authorizing for disclosure is: (CHECK ALL THAT APPLY).

___Psychiatric Evaluation ____Progress Notes ____Medication Records____Billing Records

___Treatment Plansor Summaries____Substance Abuse Records_____Lab Tests / Study Results_____Other (Specify)___

Purpose of Disclosure: ( ) Request of authorized individual patient
( ) Continuation of care by another clinician
( ) In support of application for insurance
( ) Security Investigation for employment.
( ) Insurance review of my claim for services
( ) For review in a legal matter
( ) To assist in educational and / or employment accommodations

This authorization will be in force and effect until revoked in writing by me via Certified Mail to NBHS I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient who may not be bound to the same confidentiality standards as my physician, and, therefore, such disclosed information may no longer be protected by federal or state law. I hold the provider at NBHS harmless for any adverse consequence derived directly or indirectly from authorized release of protected health information.

_____ _____
Signature of Patient or Authorized Individual Date

_____(Print Name)

NORTHVIEW BEHAVIORAL HEALTH SERVICES PLLC

1321 West Randol Mill Rd, Ste 105, Arlington, TX 76012

HEALTH INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED & DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

UNDERSTAND YOUR HEALTH RECORD INFORMATION

This notice describes the practice of our clinic. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at NBHS. This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

Your Health Information Rights

Although your health record is the physical property of NBHS, the information belongs to you. You have the right to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, healthcare operations and as to disclosures permitted to persons, including family members involved with your care as provided by law. However, we are not required by law to agree to a requested restriction.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.
- Revoke your authorization disclose health information except to the extent that action has already be taken.

You may exercise your rights set forth in this notice by providing a written request, except for requests to obtain a paper copy of this notice to the Practice Administrator at NBHS

Our Responsibilities:

In addition to the responsibilities set forth above, we are also required to:

- Maintain the privacy of your health information
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you.
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.
- We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change, we are not required to notify you, but we will have the revised notice available at your request.
- We will not use or disclose your health information without your written authorization, except as described in this notice.

Examples of Disclosures for Treatment, Payment, Health Care Operations and As Otherwise Allowed By Law

The following categories describe different ways that we use and disclose medication information. For each category, we will explain what we mean & give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information should fall within one of the categories.

We will use your health information for treatment. For example: We may disclose medical information about you to your primary care physician or subsequent health care providers with copies of various reports to assist in treating you once you are discharged from NBHS.

We will use your health information for payment. For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that may identify you, as well as your diagnosis.

Business Associates: There are some services provided in our organization through agreements with business associates. Examples including: copying services, accounting services, computer services, etc. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communications for treatment and health care operations: We may contact you to provide appointment reminders or information about treatment alternatives or other health related benefits and services that may be of interest to you. We may leave appointment reminders on your answering machine or voicemail at home or work, or with a person answering the telephone.

Worker's compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law. For example: You may apply for Disability Insurance Benefits or Life Insurance. Your insurance carrier may request medical information to review your application.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and/or law enforcement purposes. We will disclose medical information about you when required or allowed to do so by federal, state, or local law.

I acknowledge that I have reviewed and accept the NBHS policy regarding Health Information Practices.

_____ _____

Parent/Guardian Signature Date

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Agather Onyango, RN, C-PMHNP

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

Communication of your treatment plan with your Primary Care Physician (PCP) is important to your overall health care. In addition, your insurance company monitors records to ensure that there is evidence of communication to the Primary Care Physician. Please sign the necessary Authorization to Release this information to your primary care physician.

I,_____, authorize Texas Behavioral Health Systems, PA to release medical information, including that pertaining to (select one below)
( ) MY
( ) My MINOR CHILD'S_____mental health and substance
Print Full Name of Minor

abuse, to my Primary Care Physician. This authorization is effective until revoked by me in writing.

My Primary Care Physician is _____

Address of Primary Care Physician _____

_____

Phone Number:_____Fax _____

_____ _____/_____/ _____
Signature Date
xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx
(Remainder to be completed by our Staff) [ ] Mailed or Faxed to PCP

To PCP : your patient_____was seen by

us on_____/_____/_____.

Treatment prescribed: Medication(s) _____

_____

Purpose: _____

Referral to Therapy: _____

Other: _____

Recommended Lab Monitoring:_____

_____

Notice to Recipient: This information is protected by Federal (42CFR, Part 2) and State laws regarding confidentiality. These statutes prohibit you from disclosing this information to anyone else. A general authorization is not sufficient in regards to mental health and / or substance abuse information.