

Appointment Date: _____

Appointment Time: _____

Clinician: _____

The Centre for Behavioral Health



New Patient Information

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PATIENT INFORMATION

Name: _____ DOB: _____ Sex: M F
Last First MI

Address: _____

City State Zip

Mailing address: Check if same as above

Address _____

City State Zip

Home Phone: _____ Cell: _____

Email: _____ SSN: _____

Marital Status: Single Life Partner Married Divorced Separated Widowed Declined

Race: American Indian or Alaska Native Asian
 Black or African American White
 Native Hawaiian or other Pacific Islander Declined

Religion: _____ Declined

Ethnicity: Do you consider yourself to be Hispanic or Latino Yes No Declined Other: _____

Preferred Language: English Other (please specify): _____

NEXT OF KIN Check if ok to contact

Name: _____ Relation to patient: _____
Last First

Address: _____ Phone: _____

Name: _____ Relation to patient: _____
Last First

Address: _____ Phone: _____

ALLERGIES No Known Drug Allergies

Medication: _____ Reaction: _____

Medication: _____ Reaction: _____

Other (latex, adhesive, food, environment): _____

MEDICATIONS None

Please list any medications you are taking (including aspirin, vitamins, supplements or any other over the counter medication).

Name of Medication	dose	How often do you take	Reason for taking

PHARMACY	Address/Cross Streets	Phone Number	Preferred
Local: _____	_____	_____	<input type="checkbox"/>
Alternative: _____	_____	_____	<input type="checkbox"/>
Mail Order: _____	_____	_____	<input type="checkbox"/>

PLEASE USE THIS SPACE FOR ANY ADDITIONAL INFORMATION

Primary Insurance Information

Insurance Name: _____ Phone: _____

Address: _____ City: _____ State _____ Zip: _____

Member ID/Policy #: _____ Group #: _____ Copay: _____

Policy Holder: Self (skip to next section)

Name: Last _____ First _____

Date of Birth: ____/____/____ SSN: ____-____-____ Sex: M F

Relation to Patient: _____

****If you have secondary insurance, please provide a copy of the card at check in.****

PARTY RESPONSIBLE FOR PAYMENT Check if same as patient

Name: _____ Last _____ First _____ DOB: _____ mm/dd/yy

Address: _____

City _____ State _____ Zip _____

Home Phone: _____ Cell: _____

SSN: _____ Relation to patient: _____

Employer: _____ Employer Phone: _____ Occupation: _____

Status: Part-time Full-time Self-Employed Retired Active Military Disabled Student
 Unemployed Unknown

CARE TEAM

Primary Care Physician: _____ Phone Number: _____

Therapist Name: _____ Specialty: _____ Phone Number: _____

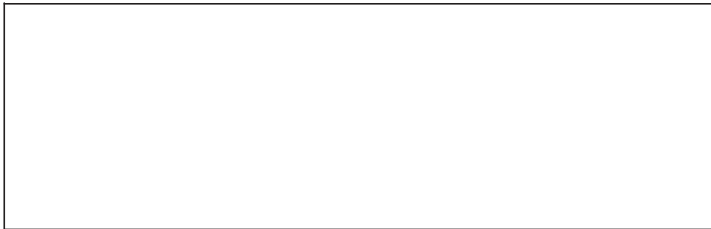
Psychiatrist Name: _____ Specialty: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

Specialist Name: _____ Specialty: _____ Phone Number: _____

How did you hear about our practice?

Referring Physician Friend/Family: Name: _____ Event: Name: _____
 Online/Practice Website Insurance Newspaper Direct Mail Television Billboard



AUTHORIZATION TO LEAVE TELEPHONE INFORMATION

The Centre for Behavioral Health is committed to ensuring the privacy and confidentiality of your medical/personal information. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

To assist us in protecting your privacy, please complete the following information:

Number to best contact you: _____ Home Cell Work

May we leave a clinical message if no answer? Yes No

May we leave information with someone other than you regarding your medical care (medication changes, laboratory results, billing issues, appointments, etc.)? If so, please list the name(s) in the space(s) below.

Billing Issues: Yes No

Clinical Issues: Yes No

Name: _____ Phone: _____ Relation to patient: _____

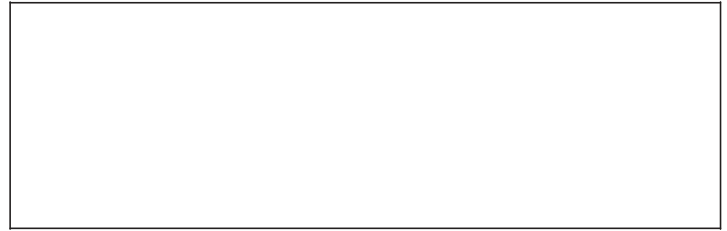
Name: _____ Phone: _____ Relation to patient: _____

Parent or Legal Guardian Signature: _____ Date: _____

Patient Name: _____ DOB: _____
Please Print

Patient Signature: _____ Date: _____

I AM AWARE THAT THIS PERMISSION CAN BE REVOKED AT ANY TIME



Consent for Behavioral Health Treatment

- 1 **CONSENT FOR HEALTH CARE SERVICES.** I authorize physicians(s), therapists(s), their assistants and/or designees to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Centura Health practices. This authorization includes, but is not limited to, medical services, diagnostic procedures, intravenous therapy, medications, injections, laboratory services, and other services or procedures, which my physician or provider considers necessary in person or telehealth. My health care providers will discuss with me the risks, benefits and alternatives to recommended treatments. I understand that health care services may be rendered by students, interns or residents under supervision. I understand that the Centura Health practice may release copies of my medical records to other physicians, practitioners and healthcare facilities for treatment and other purposes, as permitted by law. I acknowledge that no promises or guarantees have been made to me regarding treatment or services rendered in by the practice.

- 2 **MEDICARE and/or MEDICAID CERTIFICATION.** I certify that the information given by me in applying for payment under the Medicare and/or Medicaid programs is correct, and I authorize the release of all information needed to act on this request. I request that payment of authorized benefits be made to the practice on my behalf for the charges for which the practice is authorized to bill in connection with these health care services.

- 3 **FINANCIAL AGREEMENT.** I understand that there is no guarantee of reimbursement or payment from any insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges of the practice and of physicians rendering services not otherwise paid by my health insurance or other payer. Estimated patient responsibility is due at the time of service. Any remaining charges are due and payable upon receipt of the bill. I understand the practice may request and use data from third parties such as credit reporting agencies in order to verify demographic data or evaluate financial options. If payment is not made within 90 days after receipt of the bill, a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt. I acknowledge and understand that any refund that I may be owed will first be applied to any outstanding balance, and the remainder will be forwarded to the address on file with the practice. **I consent to be contacted by regular mail, or by e-mail regarding any matter related to my account by the practice or any entity to which the practice assigns my account. I also consent to the use of any updated or additional contact information that I may provide by the practice or any entity to which the practice assigns my account. Missed appointments or missed sessions which have not been canceled at least 24 hours in advance will be charged a fee of \$50.00 and is due prior to attending your next session.**

- 4 **COMMUNICATIONS CONSENT.** By providing my cell or other phone number(s), I expressly consent to receive communications from the practice, its agents or business associates at any numbers I provide or that are later acquired, to be used to contact me by live agent, voice mail, text message, using an auto dialer or other computer-assisted technology, pre-recorded message, or by any other form of electronic communication for any purpose, including scheduling, notifications, confirmations, reminders, instructions, accounting, billing, assignment of benefits, and/or collections. I understand that depending on my phone plan, I could be charged for these calls or text messages. I agree to provide new numbers if my numbers change. Providing these numbers is not a condition of receiving healthcare services.



Consent for Behavioral Health Treatment

- 5 **PREAUTHORIZATION REQUIREMENTS.** I understand that it is my sole responsibility to verify all pre-authorizations are in place and to comply with all requirements of any insurance plan upon which I am relying for coverage of the practice's and physicians' charges. I also understand that my insurance may require an office visit referral from my primary care physician to see a specialist. It is my responsibility to contact my primary care physician and acquire the necessary referral prior to my scheduled appointment. If a referral is not obtained prior to my appointment, I may be financially responsible for the charges incurred during the visit.
- 6 **ASSIGNMENT FOR DIRECT PAYMENT.** I authorize and direct that payment of any insurance or healthcare benefits otherwise payable to me for health care services or goods be made directly to the practice and my physicians. I understand that I am financially responsible to the practice or my physicians for charges not covered or paid pursuant to this authorization.
- 7 **ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES.** I acknowledge that Centura Health has offered me a copy of its Notice of Privacy Practices. I understand that the Notice of Privacy Practices is also electronically available on Centura Health's web-site. I understand this acknowledgment in no way affects the care I shall receive.
- 8 **EMERGENCY AFTER HOURS PROCEDURES.** If you are having a medication side effect that seems severe, are feeling suicidal, or having a psychiatric emergency, please call 911 or have someone drive you to the nearest emergency room.

By initialing one of the boxes below, I acknowledge:

- I have been offered and accepted a copy of the Notice of Privacy Practices**
- I have been offered and declined a copy of the Notice of Privacy Practices**

Practice Representative Comments: _____

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS AND HAVE RECEIVED A COPY HEREOF. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS.

SIGNATURE OF PATIENT OR LEGALLY RESPONSIBLE PERSON NAME (PRINT)	DATE	TIME

RELATIONSHIP / REASON WHY PATIENT IS UNABLE TO SIGN _____

ADDRESS OF PATIENT (street, city, state, zip) _____



PATIENT BILL OF RIGHTS

Patient Rights:

Centura Health Hospitals support the rights of all patients across the lifespan including geriatric, adult, adolescent, pediatric, infant and neonatal populations. These rights may be exercised through the patient individually or through their authorized surrogate decision maker.

You have the right to . . .

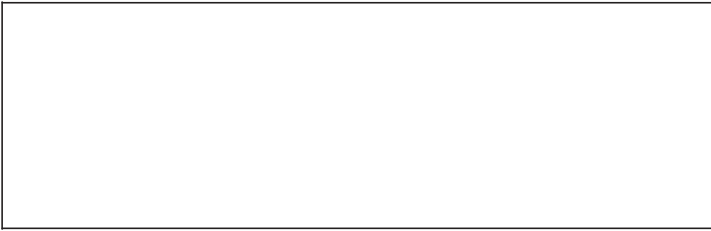
1. Be informed of your patient rights in advance of receiving or discontinuing care when possible.
2. Receive care, treatment and visitation regardless of disability, national origin, culture, age, color, race, religion, sex, gender identity, sexual orientation. No one is denied examination or treatment of an emergency medical condition because of their source of payment.
3. Give informed consent for all treatment and procedures recommended.
4. Be informed of your health status/prognosis, including unanticipated outcomes of care and the treatment and services related to serious preventable adverse events.
5. Participate in all areas of your care plan, treatment, care decisions, and discharge plan.
6. Receive appropriate assessment and prompt management of your pain.
7. Be treated with respect and dignity.
8. Experience personal privacy, comfort and security to the extent possible during your stay.
9. Be free from restraints or seclusion imposed as a means of coercion, discipline, convenience or retaliation by staff.
10. Confidentiality of all communication and clinical records related to your care and receive a copy of our Notice of Privacy Practices to inform you how your personal medical information can be used and disclosed and your rights related to your medical information.
11. Have access to telephone calls, mail, and other communication devices. Any restrictions to access will be discussed with you, and you will be involved in the decision when possible or appropriate.
12. Choose a "visitor" who may visit you, including but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and your right to withdraw or deny such choice at any time. You also have the right to select an identified "support person" who can make visitation decisions should you become incapacitated.
13. Have the right, if hospitalized, to designate at least one post-discharge caregiver who will assist you with basic tasks following your discharge and, along with you or your authorized surrogate decision maker, provide consultation on your discharge plan. Designating a post-discharge caregiver does not mean the person you have designated is obligated to care for you.
14. Be communicated with in a manner you can understand which is tailored your age, language, understanding and ability including access to interpreter services and communication aides, at no cost.
15. Have access to pastoral/spiritual care.
16. Receive care in a safe setting.
17. Be free from all forms of abuse, neglect, mistreatment, or exploitation.
18. Have access to protective services (e.g., guardianship, advocacy services, and child/adult protective services).
19. Request medically necessary and appropriate care and treatment.
20. Refuse any drug, test, procedure, or treatment and be informed of the medical consequences of such a decision.
21. Consent to or refuse to participate in teaching programs, research, experimental programs, and/or clinical trials.
22. Receive information about Advance Directives. Set up or provide Advance Directives and have them followed. Designate an authorized surrogate decision-maker as permitted by law and as needed.
23. Participate in decision-making regarding ethical issues, personal values or beliefs.
24. Have a family member or representative of your choice and your physician promptly notified of your admission to the hospital, upon request, if hospitalized.
25. Know the names, professional status and experience of your caregivers.
26. Have access to your medical records within a reasonable timeframe.
27. Be examined, treated, and if necessary, transferred to another facility if you have an emergency medical condition or are in labor, regardless of your ability to pay.
28. Request and receive, prior to the initiation of non-emergent care or treatment, the charges
(or estimate of charges) for routine, usual, and customary services and any co-payment, deductible, or non-covered charges, as well as the facility's general billing procedures including receipt and explanation of an itemized bill. This right is honored regardless of the source(s) of payment.
29. Be informed of the hospital's complaint and grievance procedure and whom to contact to file a concern, complaint or grievance.

The Centre for Behavioral Health



BH Bill of Rights

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Note: If you have financial issues or questions, please contact Centura Consumer Operations at (303) 715-7000. Toll free: 1-888-269-7001

- a. Our priority is for you to have a positive patient experience. If your concerns are not being resolved with your immediate care giver or the department manager or administrative staff, please call the Patient Care Representative/Advocate or access the hospital operator by dialing "0".
- b. You may also contact The Health Facilities Division of the Colorado Department of Public Health and Environment or the Kansas Department of Health and Environment and the Office of Civil Rights directly regardless of whether you first used the hospital's complaint and grievance process.

The Colorado Department of Public Health and Environment
4300 Cherry Creek Drive South Denver, CO 80222-1530
Telephone: (303) 692-2827

The Kansas Department of Health and Environment
1000 SW Jackson, Topeka, Kansas 66612
Telephone: (785) 296-1500

The Office for Civil Rights
Department of Health and Human Services 999 18th Street, South Terrace, Suite 417 Denver, Colorado 80202
Telephone: 303-844-2024
TDD 303-844-3439
Fax: 303-844-2025

- c. If you received care in a hospital, emergency department, home care or hospice and if after speaking with one of their representatives your complaint remains unresolved, you may contact The Joint Commission:

The Joint Commission
Division of Accreditation Operations, Office of Quality and Patient Safety
One Renaissance Boulevard Oakbrook Terrace, IL 60181 Telephone: 1-800-994-6610 E-Mail: complaint@jcaho.org
Fax: (630) 792-5636

You also have the right to file a complaint with the appropriate oversight boards including the Colorado Board of Medical Examiners, the Colorado Dental and Podiatry Boards and the Colorado Department of Regulatory Agencies. For Kansas hospitals, this includes the Kansas State Board of Healing Arts, the Kansas Board of Nursing and the Kansas office of Health Occupations Credentialing. Contact information will be provided by a hospital representative upon request.

**Patient Responsibilities:
You have the responsibility to . . .**

- 1. Ask questions and promptly voice concerns.
- 2. Give full and accurate information as it relates to your health, including prescription and non-prescription medications.
- 3. Report changes in your condition or symptoms, including pain, and request assistance of a member of the health care team.
- 4. Educate yourself. Learn about the medical tests that are being performed and understand your treatment plan.
- 5. Follow your recommended treatment plan.
- 6. Be considerate of other patients and staff.
- 7. Secure your valuables.
- 8. Follow facility rules and regulations.
- 9. Respect property that belongs to the facility or others
- 10. Understand and honor financial obligations related to your care, including understanding your own insurance coverage.

Patient Signature: _____

Date: _____ Time: _____