Dayton Behavioral Care

The following information is required for our files. **PLEASE PRINT NEATLY**							
Last Name:	First Name:	MI:	Suffix:				
SSN#:	Date of Birth:	Age:	Gender (At Birth): Preferred Gender: Sexual Orientation:				
Home Phone:	Work Phone:	Cell Phone:	Email:				
Home Address, City, State, Zip Code:							

Employed: Yes No Full Time: Part Time: Student: Full Time: Part Time: Disabled:

Employer: ______________________________ Occupation: ________________________________ Retired:

Marital Status: Single Married Divorced Separated Widow Widower
Spouse's Name: Number of Children:

Race: Ethnicity: Primary Language:

WE MUST have a number where we can reach you OR LEAVE A MESSAGE. Please provide the main number you would like our office to use when communicating with you. Please provide at least one emergency contact we can call in case of an emergency regarding your mental health or medical condition, or in the instance that we cannot reach you by the numbers provided.

Primary number for patient:	**Emergency Contact 1: (Name, relationship & phone)**	**Emergency Contact 2: (Name, relationship & phone)**
___________________________	____________________________	____________________________
	____________________________	____________________________
	____________________________	____________________________

PATIENT or LEGAL GUARDIAN SIGNATURE: _____________________________ DATE: ____________

Family Physician Name: _____________________________________ Phone: ______________________________

Were you referred to this office? YES NO Name of Referring Provider: ___________________________

PATIENT DEMOGRAPHICS

***FOR OFFICE USE ONLY: Information entered into EMR _________________ Date: ___________**

INSURANCE

Is this insurance policy in your name? YES NO ***Please present your insurance cards to the receptionist and only put the names of the insurances to the right. ***	Only write the company names below, do not need to include any other information. 1. Primary Insurance: ______________________________ 2. Secondary Insurance: ____________________________ 3. Tertiary Insurance: _______________________________

****If the insurance policy is under your spouse, parent, OR the patient is a minor- you MUST fill out the next section.**
If you do not know all the information required please contact the primary holder of your insurance policy for that information**

Last Name	**First Name**	**MI**	
Street Address	**City**	**State**	**Zip**
SS#	**Date of Birth**	**Age**	**Employer**
Home Phone	**Cell Phone**	**Relationship**	**Email**

Dayton Behavioral Care Office Policies

Please familiarize yourself with our office policies. If you would like a copy, please ask reception. If you have any questions, please call our office or as reception.

1. Cancellations:

   A. There will be a **$50-dollar** cancellation fee charged to your patient account for any cancellations with less than a 24-hour (one business day) notice.
   B. If your appointment is scheduled on Monday or following a long weekend, please call on the preceding Friday to cancel. If it is after office hours, please leave a message.
   C. Charges for your last-minute cancellation fees are **NOT COVERED** by your insurance and are due and payable to any further appointments.
   D. After-hours-please leave a detailed message for our secretaries and a convenient time to return your call to reschedule.

2. No-Show:

   A. There will be a **$50-dollar** no show fee charged to your patient account for any no missed appointments. Charges for your missed appointment are **not covered** by your insurance.
   B. If the patient misses 2 consecutive scheduled appointments, a letter will be sent to the patient's home. If the patient does not contact the office in 7 business days, or does not show

for another scheduled appointment (third); the patient will be dismissed from the practice. The clinician will help refer the patient to another provider in the area, and will provide a 30-day supply of medication.

3. Appointment Reminders:

   A. **Appointment reminder calls are made as a courtesy**. Patients are responsible for keeping track of their appointments. We will call 1-2 business days prior to remind you of your appointment.
   B. If our office tries to reach you for an appointment reminder and are unable to leave a voicemail, it is the patient's responsibility to return our call to cancel or reschedule that appointment if you are unable to keep the appointment.
      - Text messages for appointment reminders are no longer available at this time.
   C. Patients are responsible for updating their current phone numbers with our office. In the event the contact number is no longer valid and we are unable to contact you for a reminder call, it is the patient's responsibility to provide us with a valid telephone number and to pay all fees accrued for missed appointments.

4. Medications:

   A. Patients receiving psychotropic medications may be required to follow-up with their provider every 3 months or sooner to ensure continuity of care.
   B. If two or more office visits have been missed, the patient must be seen before any additional prescriptions will be written or called in to your pharmacy.
   C. Requests for refills MUST be in 72-hours before you are scheduled to run out of your medication. All benzodiazepines must be called in 72 hours in advance for the office staff to get the clinicians signature. All stimulants must be called in 5 days in advance. SAME DAY RE-FILLS CANNOT BE GUARANTEED TO BE REFILLED AND YOU MAY PUT YOURSELF AT RISK FOR WITHDRAWAL SIDE EFFECTS.
   D. All patients on stimulants or benzodiazepines may be asked to see their individual clinicians every other month to receive a refill. The month in between, you may pick up the script at the office window during normal business hours; or your clinician can e-script the medication to your pharmacy. Please make sure to have your PHOTO ID in hand; no prescription will be given out without a valid photo ID. Random drug testing may be done at the clinician's choice using an oral swab test or urine drug screen.
   E. Samples are a professional courtesy from the drug company to you the patient. Samples may be given out for varying lengths of time depending on your clinician's preference. They are a courtesy not an expectation.

5. Insurance:

   A. Patients are responsible for being aware of their current insurance coverage. This includes the following details:
      - Deductible and/or "out-of-pocket"
      - Co-pay
      - Need for pre-certification
      - Current coverage and visits remaining

- **Any CHANGES in your coverage, insurance carrier**
- Out-of-network benefits

B. Although our secretaries and billing staff are here to help you; ultimately, the above items are your responsibility. Please call the office IMMEDIATELY to up-date expired insurance or a change to a new carrier. In office visits, fees, etc. that occur during the lapse in coverage will be the sole responsibility of the patient and must be paid in full.

C. If the secretarial staff has tried to reach your insurance company with a prior authorization request and the insurance company does not respond to this request**; the patient will be called before the appointment to follow-up with his/her company before they can be seen by the provider.**

D. We are now requiring insurance cards to be presented to reception at every single office visit. Please bring your card with you and have it ready to hand to the receptionist when checking in for your appointment.

6. Disability:

A. Disability paperwork WILL NOT BE FILLED OUT ON AN INITIAL appointment.
B. A patient must be seen by a provider at this practice 3-6 times, depending on the individual provider, before disability forms will be filled out.
C. Please bring your disability forms in to the office, and allow 7 business days for these forms to be completed by your clinician. The charge for individual disability packets is $50.00 per packet due before the paperwork is completed.
D. Records will be requested from your previous provider from this office, but, ultimately it is your responsibility to follow-up with that request in a timely manner.

7. Paperwork:

A. All request for letters, 1 page documents, or letters for jury duty need to be requested 7 business days in advance; and will be charged $25.00 per letter/document.

8. Messages and After Hour Calls:

A. Messages will be returned within 1-3 business days of receiving them or sooner. Please leave your date of birth, name, telephone number where you can be reached, and a convenient time to call.
B. Messages received after 5:00 pm on Friday will be considered as received on the following business day.
C. Please do not leave non-urgent messages such as refill requests or scheduling appointments marked “urgent” on our voicemail. That option is ONLY for actual emergencies. If it is an emergency please see below for instructions.
D. Any URGENT or LIFE-THREATENING message, issue, concern, or problem that requires IMMEDIATE attention should be addressed by:
   - Calling 911
   - Going to your local or closest Emergency Room
   - Calling the Crisis Care Hotline (937-224-4646) open 24/7

Please note: This information will be disclosed to Dayton Behavioral Care, LLC from records protected by federal confidentiality rules. The federal rules prohibit Dayton Behavioral Care, LLC from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R., Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.

STIMULANT/BENZODIAZEPINE PRESCRIPTION POLICY

Examples of commonly prescribed stimulants and benzodiazepines are: Adderall, Ritalin, Concerta, Vyvanse, Ativan, Klonopin, Xanax, Valium, Temazepam. If you are unsure if you are prescribed medications categorized as these classes of drugs, please ask reception.

- If you are not currently prescribed these, please check the box below to indicate that this does not apply to you.

I am currently not prescribed any stimulants or benzodiazepines.

All new patients entering the practice on a stimulant or benzodiazepine are not guaranteed the provider you are seeing will continue these medications. The patient's history, signs, symptoms, provider history, and records will be used to decide continuation of these medications on an individual basis.

Those patients entering the practice or currently in the practice on these medications must consent to a random urine drug testing or oral swab if asked. Failure to agree to such a test will result in your provider/clinician reserving the right to discontinue your medication.

A patient's urine drug screen found with marijuana, other recreational drugs, illicit street drugs, or other benzodiazepines/stimulants, not prescribed by a provider in this practice, is subject to having your medication tapered and discontinued. Such patients will be referred out of this practice to another provider.

Dayton Behavioral Care reserves the right to decide the frequency of visits for any patient prescribed a stimulant, benzodiazepine, or other controlled substance; in accordance to changing and evolving FDA guidelines, current standard of care practices, and CMS and other insurance guidelines.

All benzodiazepines require a 72-hour notice to refill and stimulants require a 5-day notice. **WE CANNOT ACCOMMODATE LAST MINUTE REQUESTS DUE TO A LARGE VOLUME OF REFILL REQUESTS.**

PATIENT SIGNATURE: ____________________________ DATE: _________________

Consent to Obtain Patient Medication History

It is very important that you and your provider discuss all your medications including over the counter drugs, supplements, or herbal remedies that you take in order to insure your recorded medication history is 100% accurate. Medication History is very important in helping healthcare providers treat your symptoms and or /illness properly and in avoiding potentially dangerous drug interactions.

I, ____________________, gave my permission to allow my mental healthcare provider to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

_______________________________ _____________

Patient/ Guardian Signature Date

FINANCIAL POLICY

Please read the financial policy and fees in full for Dayton Behavioral Care, LLC.

It is the sole responsibility of the patient or the legal guardian to pay in full copays, balances, and any outstanding fee before your next visit with the clinician.

Monthly statements will be sent out and are due upon receiving the statement. ALL unpaid balances over 30 days from receiving the statement will incur a 4% fee of the total unpaid balance plus an additional $5.00 charge for secretarial and postage fees. Any unpaid balances of over 90 days are subject to be sent to a collection agency.

Payments will be accepted by phone with a debit or credit card or may be mailed directly to our office address located on your statement.

PRINT PATIENT/GUARDIAN NAME:____
SIGNATURE OF PATIENT or RESPONSIBLE PARTY: _______________________
DATE: _________________

HIPPA PRIVACY PRACTICES

I have read and acknowledged the Notice of HIPAA Privacy Practices (Posted on wall at reception window, if you would like a copy for yourself, please ask reception.)
Print Patient Name: ______________________________
Patient or Guardian Signature: _______________________________ Date: __________

OFFICE POLICY PATIENT ACKNOWLEDGEMENT

I have read and acknowledged the Dayton Behavioral Care Office Policies (If you would like a copy for yourself, please ask reception.)
Print Patient Name: ______________________________
Patient or Guardian Signature: ________________________________ Date: __________

For Office Use Only:

Date Reviewed	Patient/Guardian Signature