BEHAVIORAL HEALTH PATIENT INFORMATION SHEET

PATIENT INFORMATION:

Medical Record #:

Name: (must have legal name) Last name:			First name:		Middle Initial:
Mailing Address:				County:	
City:	State:	Zip:		Date of birth:	
Social Security #:		Sex: M F		Marital Status: M S W D	
Email address:			Phone #:		Cell #:
Disabled ☐	Retired ☐	Employed ☐	Employer:		Work Phone:
Emergency Contact:			Relation:		Phone #:
Language:	English ☐	Spanish ☐	Japanese ☐	Other ☐	Unavailable ☐
Ethnicity:	Non Hispanic ☐	Hispanic ☐	Declined ☐		Unavailable ☐
Race:	White ☐	Black/African American ☐	American Indian/ Alaska Native ☐		Asian ☐
	Native Hawaiian/Other Pacific Islander ☐	Multiracial ☐	Declined ☐		Unavailable ☐
Who is your primary doctor:			Who are you seeing today:		

RESPONSIBLE PARTY DATA (If other than the patient):

Name:			Relation to patient:	
Mailing Address:			County:	
City:	State:	Zip:	Date of birth:	
Social Security #:		Phone #:		Cell #:

INSUREDS'S INFORMATION:

Our goal is to file your insurance correctly; a front and back copy of your current card will help ensure this. If you do not have insurance, please check with the front desk regarding payment options that are available.

PRIMARY Insurance Name:	**SECONDARY** Insurance Name:
Primary Insurance - Insured's Name:	Secondary Insurance -Insured's Name:
Primary Insured's Social Security #:	Secondary Insured's Social Security #:
Primary Insured's Date of Birth:	Secondary Insured's Date of Birth:

AUTHORIZATION FORE REALEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize Behavioral Health Center/Clinic to furnish any and all information to my insurance carrier(s) concerning my illness and/or treatment.

I hereby assign all rights, benefits and interest in all plans of health insurance, cases or claims arising from my condition, whether against an insurance company, corporation, individual or any other entity, to Behavioral Health Center/Clinic. I understand that I am ultimately responsible for payment for all charges if not otherwise paid (unless prohibited by law or plan contract). I further understand that any amount paid in excess of the regular charges will be refunded as appropriate to the third party payor or to the patient or guarantor. However, in cases where the patient or guarantor has other outstanding accounts, the overpayment will be added to the outstanding account(s).

Date/Time: _____ Patient/Guardian Signature: _____

Date/Time: _____ Center/Clinic Employee: _____

DISCLOSURE OF PERSONAL HEALTH INFORMATION:

Behavioral Health Center/Clinic will not discuss your personal information with anyone except those allowed under federal and state law without your authorization. Please list the names and relationship of those you authorize us to discuss your personal health information.

Contact Name	Relationship	Daytime Phone
Contact Name	Relationship	Daytime Phone
Contact Name	Relationship	Daytime Phone

NMMC –BEHAVIORAL HEALTH CENTER
CONSENT FOR TREATMENT,ADMISSION, AND RELEASE OF HEALTH INFORMATION

NAME OF PATIENT: _____

DATE: _____

PATIENT NUMBER: _____

1. **CONSENT FOR TREATMENT:** I request and voluntarily consent to the usual hospital services while a patient at NORTHMISSISSIPPIMEDICALCENTER,INC.,d/b/aNMMC–BEHAVIORAL HEALTH CENTER ("Hospital"), as well as the diagnostic laboratory (testing of the blood and other bodily fluids) and x-ray procedures (including intravenous injection of contrast material) and medical and/or surgical treatment, including administration of anesthesia and other treatment as deemed necessary by my attending physician, his assistants or other designated physicians. The Hospital is authorized to retain, preserve, and use for scientific or teaching purposes, or dispose of, at its convenience, any specimens or tissue removed from my body during hospitalization or treatment. I understand that photographs may be taken for clinical and/or educational purposes and hereby consent thereto. I also understand that if any such photographs are taken for educational purposes, any and all such photographs will not be retained as a part of my permanent medical record.

2. **MEDICAL CARE:** During hospitalization or treatment at Hospital, I, as a patient, will be under the professional care of a physician. I acknowledge that many physicians on the medical staff of the Hospital are not employees or agents of the Hospital, but are independent physicians who have been granted the privilege of using Hospital facilities for the care and treatment of their patients. I understand that no guarantees have been made as a result of examination or treatment while in the Hospital.

3. **COMPLIANCE WITH RULES AND REGULATIONS:** In consideration of admission and/or treatment, I agree to abide by the rules of the Hospital, including no smoking anywhere on hospital property.

4. **PERSONAL VALUABLES:** Valuables, including money, jewelry, glasses, dentures, documents and other personal Items should be kept at home. For the convenience of the patient, safekeeping of the patient's valuables is available, with- out charge, by the hospital. I agree that the Hospital will not be liable for the loss or damage to any personal property of the patient brought to the Hospital except that which is properly deposited with the hospital.

5. **RELEASE AND RESPONSIBILITY:** I hereby agree, acknowledge and understand that the Hospital is not responsible for injuries sustained by use of my own personal equipment - electrical, mechanical or otherwise. I further understand and agree that should I leave the Hospital without the consent of my physician(s) (against medical advice), I hereby relieve my physician(s) and the Hospital of all responsibility for such action.

6. **CONSENT TO DESTROY X-RAY AND GRAPHIC DATA:** I hereby authorize the Hospital to dispose of, at its dis- cretion, any specimens or tissues taken from my body during my hospitalization and to retire x-ray film and any other graphic data which may be generated during my stay four (4) years after they are created if a proper report is in the medical record. However, to the extent any such x-rays and/or other graphic data are stored in a digital and/or electronic format, Hospital may dispose of such x-rays and/or other graphic data, at its discretion, six (6) years after they are created.

7. **ASSIGNMENT OF BENEFITS:** As a patient, I hereby make the assignment of benefits as set forth below:

MEDICARE AND/OR MEDICAID: I hereby request that payment of authorized Medicare/Medicaid benefits to or on my behalf for services furnished in or by the Hospital, shall be made to the Hospital, and I specifically assign such benefits to the Hospital. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for certain services not deemed medically necessary by Medicare/Medicaid are not authorized under the Medicare/Medicaid Program and that I may be responsible for the entire charge incurred unless other third party coverage is available. I also understand all deductibles are due unless they have been met within the period specified by Medicare.

INSURANCE: I hereby assign to Hospital all rights, benefits and interest under any insurance policy, health plan, workers' compensation or other third party payor liable to me, in consideration for services rendered by the Hospital. I hereby authorize payment directly to Hospital by any insurance policy, health plan or third-party payor for treatment received at the Hospital. I hereby authorize payment directly to the Hospital of Worker's Compensation coverage for medical expenses for medical treatment received at the Hospital. I hereby authorize payment directly to the Hospital of all third-party liability insurance coverage, third party payor, health plan and individual liability insurance coverage for medical expenses incurred as a result of any accident, injury or illness for which I received treatment at the Hospital.

PHYSICIANS: I also assign benefits to all physicians involved in the care of this period of illness or treatment.
PLEASE NOTE: Most physicians' billings including, but not limited to, Radiology, Anesthesiology, Pathology, Emergency Room, attending or consulting physicians will be billed separately by the physician.

8. **FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible to the Hospital for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges and other items not paid by insurance, health plan or other third-party payors are due and payable upon admission based on the best estimates available as determined by Hospital. Charges remaining on this account not covered by insurance, health plan or other third-party payor, are payable upon demand. I also agree that in case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, all reasonable collection fees, reasonable attorney fees, cost and other expenses will be paid by me. I also understand, agree and authorize Hospital to verify employment status for the purpose of processing my Hospital bill for payment. **For those insurers/health plans without a contract, neither partial payment nor the cashing of an insurer's/health plan check will be considered as payment in full on behalf of patient. All payments from insurers/health plans will be reviewed for appropriateness.**

9. **NON-CERTIFICATION OF ADMISSION:** I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third-party payor, I am responsible for assuring certification is obtained from the insurance company, third-party administrator or health plan for the admission date indicated. If certification is not obtained, I further agree that in the event the insurance, health plan or other third party payor denies either all or part of the payment on the Hospital account, I will pay the account in full upon demand from the Hospital.

10. **CONSENT FOR THE RELEASE OF HEALTH INFORMATION FOR BILLING AND PAYMENT PURPOSES:**
I hereby consent to the release of my health information (medical records, medical results and any and all other health information) by Hospital or any physician involved in my care for the purpose of: billing; claims management; medical data processing; eligibility documentation; reimbursement; and certification to any insurance company, third-party payor, health plan or government agency which is necessary for the billing and payment of my account

11. **CHARITY CARE:** I understand that if I am uninsured and unable to pay for care, that financial assistance may be available. If I need assistance, I can contact (662) 377-3219 or http://www.nmhs.net for further information about financial assistance for uninsured patients. I understand that charity assistance will be denied if I fail to truthfully, and timely, provide information to verify my eligibility.

12. **CONSENT TO CONTACT:** I hereby authorize the Hospital and its respective employees, agents and contractors to contact me about obtaining potential financial assistance for my account(s) and/or for collection services about my account at the current or any future telephone number (including wireless telephone numbers) listed with my account. I hereby agree that methods of contact may include using pre-recorded or artificial voice and/or an automated telephone dialing system.

_____
Initials

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAVE READ PARAGRAPHS 1-12 OF THIS DOCUMENT, UNDERSTAND ITS CONTENT, AND AGREE TO ITS TERMS.

_____ _____
Signature of Patient DATE / TIME

_____
Witness

WHEN PATIENT IS A MINOR OR INCOMPETENT TO GIVE CONSENT: I hereby consent for the Patient.

_____ _____
Signature of Authorized Person DATE / TIME

_____
Relationship to Patient

_____
Witness

NO SHOW / LATE ARRIVAL POLICY

Behavioral Health Center/Clinic policy regarding missed and/or late appointments is as follows:

Three (3) missed appointments may result in termination from the Center/Clinic as an active, continuing patient. This means that I failed to notify the Center/Clinic twenty-four (24) hours in advance of my appointment and that I did not arrive at the Center/Clinic for my appointment.

I also understand that if I arrive late for my appointment, I may be rescheduled, dependant on the provider's schedule.

I understand this policy regarding my missed and/or late appointments as verified with my signature.

_____ _____

Signature of patient or guardian Date

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

I acknowledge that I have been given and received a copy of North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics' Notice of Privacy Practices. Your acknowledgment does not mean that you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means that you acknowledge receipt of a copy.

_____

Signature of Patient DATE

When patient is a minor or incompetent to sign Acknowledgment:

I hereby acknowledge that I have been given and received a copy of North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics' Notice of Privacy Practices on behalf of patient. Your acknowledgment does not mean that you agree with our Notice of Privacy Practices or that you have read our Notice of Privacy Practices; it only means that you acknowledge receipt of a copy.

_____

Signature of Patient DATE

_____

Relationship to Patient

When Patient or Authorized Person refuses to sign Acknowledgment:

Patient (or Authorized Person) was given a copy of Notice of Privacy Practices but refused to sign the Acknowledgment.

_____

NMMC Employee DATE

North Mississippi Medical Centers' and Clinics' Summary Notice of Privacy Practices

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Este aviso describe cómo la información médica sobre usted puede ser utilizada y divulgada y cómo usted puede conseguir el acceso a esta información. Por favor revise con cuidado.

Si usted quiere, nosotros podemos hacer una copia de este aviso de la práctica de la privacidad disponible en español.

We understand that medical information about you and your health is personal. North Mississippi Medical Centers' hospitals and North Mississippi Medical Clinics and their affiliated companies ("NMMC") are required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this Notice of our legal duties and privacy practices with respect to your health information. Employees, staff and physicians at NMMC will follow this notice. A detailed Notice of our Privacy Practices is listed behind this summary and on our website.

How NMMC May Use or Disclose Your Health Information

NMMC protects the privacy of your health information. For some activities, we must have your written authorization to use or disclose your health information. However, the law permits NMMC to use or disclose your health information for several purposes without your authorization, including but not limited to:

For Treatment. We may use and disclose information obtained by NMMC employees, staff, physicians and other health care providers will be used to treat you.

For Payment. We may use and disclose your health information so that NMMC and physician(s) may bill and collect payment from you, an insurance company, Medicare, Medicaid or other third party.

For Health Care Operations. We may use and disclose health information about you for health care operations. These uses and disclosures are necessary to run NMMC and make sure that you receive appropriate care.

As Required by Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health Risks. We may disclose health information about you for public health activities. These activities generally include, but are not limited to, the following: (1) to prevent or control disease, injury or disability, and (2) to notify the appropriate government authority if we believe a person has been the victim of abuse, neglect or domestic violence.

For Health Oversight Activities. We may disclose health information to a health oversight agency for activities which are necessary for the government or an oversight agency to monitor and investigate the health care system.

Lawsuits and Disputes. We may disclose health information about you in response to a court order or subpoena, if you are involved in a lawsuit or legal dispute.

For Specific Government Functions. We may disclose health information for the following specific government functions: (1) military personnel, as required by military command authorities; (2) health of inmates, to a correctional institution or law enforcement official; (3) in response to an appropriate request from law enforcement; and (4) for national security reasons.

To Business Associates. To those companies that perform service on behalf of NMMC, including transcription services, consultants and collection agencies.

Other Uses of PHI. Other uses and disclosures of your PHI not covered by this notice or the laws that apply to us will be made only with your written authorization.

When NMMC May Not Use or Disclose Your Health Information

Except as described in our Notice of Privacy Practices, NMMC will not use or disclose your health information without your written authorization. If you do authorize NMMC to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

You Have the Following Rights With Respect to Your Health Information

You have the right to request restrictions on certain uses and disclosures of your health information. NMMC is not required to agree to a restriction that you request.

You have the right to inspect and request a copy, for a fee, of your health information.

You have the right to request that NMMC amend your health information that you believe is incorrect or incomplete. NMMC is not required to amend health information that is accurate and complete.

You have a right to receive an accounting of disclosures of your health information we have made after April 14, 2003 for purposes other than disclosures (1) for NMMC's treatment, payment or health care operations, (2) based upon your authorization to others, and (3) for certain government functions.

You may request communications of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

To Report a Problem or File a Complaint

If you believe your privacy rights have been violated, you can report a problem or file a complaint with the Privacy Officer at (888) 246-2808 or with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation or denial of treatment for filing a complaint.

Changes to This Notice of Privacy Practices

NMMC reserves the right to change this Notice and post the changes. Upon request, we will provide a revised Notice to you.

Visit us online at: www.nmhs.net