Altahir Behavioral Health P.L.C

1. Reason for psychiatric visit (symptoms/diagnosis)?

2. If any, list of prescribed current medications and/or psychiatric medications tried:

Please circle the following; otherwise, please write additional information.

3. Are you seeing a therapist/counselor?

Yes No

4. Please circle if applicable, are you pregnant or trying to conceive?

Yes No N/A

5. Do you have a device that is capable of Virtual Appointments (wifi, camera, mic, and audio)?

Yes No

6. Please choose a location closest to you in case we go back in-person:

Falls Church Stafford

7. Choose time for scheduling purposes:

Mon Tue Wed Thurs Fri

Morning Mid-day Noon Afternoon Anytime

8. Preferred Provider:

Male Female Any

Altahir Behavioral Health P.L.C

Patient Registration Form

Referred By: _____

Patient Name: _____ Sex: M / F / Declined to provide
Last First MI

Preferred Pronouns: _____ DOB: ____/_____/_____ Age: _____

Nickname(s): _____ Marital Status: S___ M___ D___ W___

Address: _____ Apt: _____

City: _____State: _____ Zip: _____

Home Phone:(_____) _____ Cell Phone: (_____) _____

Email Address: _____

Employer Name: _____ Occupation: _____

Address: _____City: _____ State _____

Emergency Contact: _____ Relationship: _____

Telephone: _____

Please fill out if you are the responsible for a Patient under 18 years old:

Name: _____ Relationship: _____

DOB: _____/_____/_____ SSN#: _____ Phone #: _____

Occupation: _____ Address: _____

Insurance Information (if a copy is not provided):

Primary Insurance: _____ Policy Holder's Name: _____

Member ID# _____ SS# (optional): _____Relationship: _____

2nd Insurance Company: _____ Policy Holder Name: _____

Member ID# _____SS# (optional): _____Relationship: _____

Pharmacy Info:

Name: _____ Phone:(____)_____ Fax: (____)_____

Address: _____

Altahir Behavioral Health P.L.C

Informed Consent to Treatment

Patient's Rights and Responsibilities

I understand that treatment offers no guarantees. By working with my provider, I can get help with the problems and concerns that I bring. I understand that I will benefit of treatment in proportion to the effort, dedication, and willingness to participate in sessions, I will not limit myself to only in office efforts. I understand that the effectiveness of treatment can be limited.

I agree to cooperate with my provider or discuss with them why I am unable to. I agree to ask any questions I may have regarding my treatment and the goals that I, along with my provider have set to reach peak wellness.

I understand that treatment will end if I am no longer willing to accept the treatment given by my provider. I also understand that I can, at any point in time, end the doctor patient relationship if I am unsatisfied with the level of care or effectiveness.

Patient Name: Guardian Name: (if patient is a minor)

_____ _____

Patient Signature: Guardian Signature: (if patient is a minor)

_____ _____

Altahir Behavioral Health P.L.C

Policies

As a growing practice, it is our goal at Altahir Behavioral Health to serve you in a caring and professional manner.

We feel it would be helpful to help make you aware of the following:

Initial after reading each statement

___ We expect our staff, patients, parent(s)/guardian(s) to always remain professional or respect of each other. If threats or foul language is being used against our practice or staff, the practice has the right to terminate the patient's account and/or decline further services.

___ Confidentiality is very important part of treatment. Please know that NO information will be released to any persons that do not have prior consent from the patient or guardian.

___ It is important that patient's (18+) or parent/guardian's responsibility to **update** the practice if any changes of the following: ***contact information, active insurance(s) card, consent to release information, or any records***

___ All late, canceled, and missed appointments are subject to a **$50.00 fee**. We require **24-hour notice** to be given. This charge will be due at your next appointment.

___ If two or more appointments are missed in a 12-month period Altahir Behavioral Health will discontinue medication management services.

___ All co-pay, deductibles or any amount not covered by your insurance company will be expected at the time of your appointment.

___ Billing cycles are 45 days after the date of service. Statements are available to be requested at any time. If questions/concerns arise, you may contact our billing department 703-828-6586. You may call our office or send a check to:

Altahir Behavioral Health
239 Garrisonville Rd. Ste. 201
Stafford, VA 22554 (703) 373-7338

___ An account that is greater than $300 outstanding balance won't be scheduled until 15% is paid towards the balance. Payment plans are available under the Office Manager's discretion.

___All copays are due **prior to the scheduled appointment time**. Failure to make your copay will result in **cancellation of appointment**.

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

Altahir Behavioral Health P.L.C

Office Policies (cont.)

It is our goal at Altahir Behavioral Health to serve you in a caring and professional manner. We feel it would be helpful to help make you aware of the following:

Initial after reading each statement

___ Patients who are **minor** are **required** to be present each appointment with a legal guardian/adult from the **Consent Form** (page 7)

__ Please allow 48 hours for provider's response of refill request to be sent to your pharmacy and 72 hours for prescription Prior Authorization completion. (Contact us three weeks in advance before medications run out)

__ If appointments are not kept according to your provider's recommendation, no refills can be issued until you are seen for your next follow-up appointment.

___ There are **no refills for controlled medications** if the patient has not been seen for **more than 90 days** (3 months).

___ You are subject to charge if a prescription is lost or misplaced.

___ Altahir Behavioral Health will not release a prescription without proper identification of a party listed on the Consent to Disclose Information Form.

___ Follow up care is very important to both you and your doctor. It is a responsibility by the patient (18+), guardian/parent to schedule. Being compliant with your appointments enables us to refill your medication in a timely manner.

___ Must have primary care provider who is apprised of any medications we are using. If your provider is unavailable, your primary care provider can provide enough day's medication until we can meet.

___ Any medical records authorization request requires practice form to be completed with patient's (18+) or parent/guardian's signature. The law allows Medical Offices **30 days** to complete the requested. However, we will put forth every effort to respond to these requests in a timely manner.

___ If you would like to keep a copy of our Office Policies, please ask receptionist. We encourage you to keep a copy for your records.

In signing below, I am stating that I fully understand the Office Policies stated above and that if I have any question they were explained to my satisfaction.

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

Altahir Behavioral Health P.L.C

ATTENTION PATIENTS

EFFECTIVE IMMEDIATELY

ALTAHIR BEHAVIORAL HEALTH PROVIDERS WILL NO LONGER BE PRESCRIBING ANY:

BENZODIAZEPINES

A list of Benzodiazepines drugs are:

Klonopin (Clonazepam)

Xanax (Alprazolam)

Librium (Chordiazepoxide)

Valium (Diazepam)

Ativan (Lorazepam)

Doral (Quazepam)

Halcion (Triazolam)

Rohypnol (Fluitrazepam)

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

Altahir Behavioral Health P.L.C

Consent to Release/Disclose Health Information

Patient Name: _____ _____ DOB: _____

I hereby request that health information be discussed with and disclosed to the family member, school official, or friend listed below. The identified below are involved in my/my child's care and agree that the provider listed above may share such information as the provider deems relevant to such individual's involvement, including appointment times, required care, prescription release and diagnosis. I understand that I have the right to revoke this consent release by delivering written notice to the provider.

Please list the Individual's legal name and Relationship to the Patient:

Name:	Relationship (Contact number/email (optional):
_____	_____
_____	_____
_____	_____
_____	_____

Please note that we will not make appointments, release information, or prescriptions to any person not named on this form. If there are no individual provided, please leave it blank and sign below.

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date

Altahir Behavioral Health P.L.C

I, _____ consent to:

__ Text message and Reminders

__ Phone Call Reminders

__ Email Reminders

_____

Printed Name of Patient or Guardian

_____ _____

Signature of Patient or Guardian Date