ABC MEDICAL PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name_____First Name_____MI_____

Date of Birth_____Gender_____Social Security Number_____

Address_____

City_____State_____Zip Code_____

Home Phone_____Cell Phone_____Work Phone_____

Provide only the phone numbers where you are authorizing us to contact you for appointment reminders, billing questions/collections, and/or general information. Are we authorized to leave a message?_____

Marital Status_____How were you referred?_____

Who can we contact in case of an emergency?_____

Relationship_____Home Phone_____Alt Phone_____

Name of Person responsible for the account(if different from patient)_____

Address_____City/WI_____Zip_____

Social Security Number_____ Date of Birth_____

INSURANCE INFORMATION

Do you have insurance coverage? (if *yes*, complete the following) _____Yes _____No

Name of your Insurance Company_____

Subscriber/Member #_____Group #_____

Subscriber Employer_____Work Phone Number_____

Is the patient the policy holder? (if *no*, complete the following) _____Yes _____No

Insurance Subscriber's Name_____Relationship_____

Subscriber's Social Security #_____Subscriber's Date of Birth_____

Do you have a *Secondary Insurance?* (if *yes*, complete the following) _____Yes _____No

Name of your Insurance Company_____

Subscriber/Member #_____Group #_____

Subscriber Employer_____Work Phone Number_____

Is the patient the policy holder? (If *no*, complete the following) _____Yes _____No

Insurance Subscriber's Name_____Relationship_____

Subscriber's Social Security #_____Subscriber's Date of Birth_____

Signature_____Date_____

(Patient or Parent/Guardian of Minor) ***A copy of the insurance card must accompany this form***

AMERICAN BEHAVIORAL CLINICS

PATIENT RIGHTS

When you receive services from American Behavioral Clinics or other outpatient clinics that are certified by the State of Wisconsin for mental health and/or chemical dependency services, you have specific statutory rights as enumerated in the Wisconsin Statures 51.61 and the Wisconsin Administrative Code HSS 94. We are including a brief summary of these rights.

You have the right to:

- Be informed of your rights verbally and in writing.
- Give informed consent acknowledging your permission to receive treatment.
- Receive prompt and adequate treatment.
- Refuse treatment you don't want.
- Be free from unnecessary or excessive medication. To receive clear information pertaining to any recommended medication, its possible benefits, side effects and alternative medication.
- Be free from drastic treatment procedures, unless you give informed consent for the treatment.
- Be free from experimental research, unless you give informed consent.
- Be free from unreasonable or arbitrary decisions pertaining to your treatment.
- Have the confidentiality of your treatment and treatment records.
- Be free from audio or visual recording without informed consent.
- Have access to information in your treatment records. While in treatment, records can be reviewed with your therapist, doctor or the Clinic Director. After treatment, records can be obtained using a Release of Confidential Information Form.
- You have the right to challenge the accuracy, completeness, timeliness and/or relevance of information in your record and the right to have factual errors corrected and alternative interpretations added.
- File a grievance with American Behavioral Clinics if your rights have been denied or limited and/or bring legal action against persons who have violated your rights.

In the event of a problem, we encourage you to initiate a complaint either verbally or in writing to the Practice Administrator or Clinic Administrator at 10424 W. Bluemound Rd. Milwaukee, WI 53226 (414) 774-1794.

If a verbal complaint is not resolved within 5 days, you will need to file a written complaint. We will handle your complaint through our formal grievance procedure.

_____ _____

Patient/Guardian Signature (Indicates I understand my Patient Rights) Date

AMERICAN BEHAVIORAL CLINICS

Informed Consent Policy (HSS 94.03)

It is policy of American Behavioral Clinics that each patient, or individual acting on behalf of a patient, shall receive specific, complete and accurate information regarding the various treatment and psychotherapy they may receive. Under normal conditions, this information shall be presented verbally by the therapist rendering the particular treatment. In instances where there is a greater possibility of the treatment resulting in unexpected or negative side effects, the information shall be provided in writing at the request of the patient or personal representative.

The patient shall always be accorded ample time to consider the information prior to agreeing to participate in the particular treatment, and shall always be provided with the opportunity to seek additional information if so desired.

The specific, complete and accurate information provided shall address each of the following areas:

1. The benefits of the proposed treatment.
2. The way the treatment is to be administered.
3. Risks or side effects from therapy and/or the risks of side effects from medications.
4. Alternative treatment modes.
5. The probable consequences of not receiving proper treatment.
6. The time period for which the informed consent is effective.
7. The patient's right to withdraw the informed consent at any time in writing.

I have read and understand the policy and procedures pertaining to my granting of informed consent for the treatment which I choose to receive and have been presented with the necessary appropriate information either verbally or in writing (if in writing, the information is attached to this consent) and having adequate time to recommended treatment regime(s). Further, I recognize that I may indicate my informed consent by signing this document, and that said document shall be retained in my clinic record; and I am entitled to receive a copy of same should I so request.

_____

Patient and Family Member(s)/Significant Other Signatures Date

_____

Guardian Signature Date

_____

Witness Signature Date

American Behavioral Clinics

Authorization to Release Insurance Information and Assignment of Insurance Benefits and Payment Plan

Print Patient Name:_____**Date:**_____

FINANCIAL POLICY

FEE PAYMENTS: Please understand that when you come for services, you and your provider automatically contract with one another. While we will do our best to assist you in verifying insurance coverage, it is ultimately your responsibility to understand your benefits. Any charges not covered by your insurance company are your responsibility. This includes deductibles, copays, co-insurances, lapses in coverage, any private pay arrangements agreed upon between you and your provider, or any charges not covered by your insurance company for other reasons determined by your insurance after services are rendered.

Please initial the following *ONLY IF YOU ELECT TO DECLINE INSURANCE BENEFITS*

*I am choosing **NOT** to use my insurance benefits to cover services._____

*I agree to pay for all professional services I receive at American Behavioral Clinics. I understand I am responsible for paying all fees, in full, at the time of services. I understand that if I do not have the payment at the time of service my appointment may need to be rescheduled._____

_____ ***Please initial the following:***

*I understand payments are due 30 days from the date of the statement. After three consecutive months, failure to make payment in full, or to make payment arrangements with our office, will result in your account being turned over for collections. If this occurs, a 33% collection charge will be added to your bill._____

*I understand that any no shows, or a cancellation that is not at least 24 hours prior to your scheduled appointment, could accrue a charge up to $85.00. I also understand that insurance companies will not cover these charges and I am therefore responsible for this payment._____

*I understand that I am responsible for any charges not covered by my insurance company including deductibles, copays, co-insurances, and lapses in insurance coverage._____

*I understand that a fee of $25.00 is charged to my account for returned payments due to non-sufficient funds and/or stop payment. I understand that if I do not have payment at the time of my next appointment my appointment may need to be rescheduled._____

*I understand that American Behavioral Clinics reserves the right to reschedule, cancel, and/or terminate services due to any therapeutic non-compliance and/or payment non-compliance._____

*I understand that American Behavioral Clinics has the right to change the fees for services without notice._____

Signature of Patient or Responsible Party:_____**Date:**_____

American Behavioral Clinics
Notice of Privacy Practices
Consent to Use and Disclose and Receipt of Privacy Notice

SECTION A: Individual Giving Consent

Patient Name:_____ Date of Birth:_____

Parent or Guardian of Patient: _____ Relationship:_____

SECTION B: To the Individual-Please Read the Following Statements Carefully

Purpose of Consent: By signing this form, you will consent to the use and disclosure of your medical records to carry out treatment, payment and health care operations as discussed in our Privacy Practice Notice. This consent is in effect until revoked by you.
Effect of Declining Consent: This consent is a condition of your treatment by us. If you decide not to sign this consent, we may decline to provide treatment to you.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of uses and disclosures we may make from your protected health information for treatment, payment, and health care operations as well as other important matters about your protected health information. A copy of our Notice accompanies this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. If changes occur, they may apply to any of your protected health information that we maintain.
Right to Revoke: You have the right to revoke this consent at any time by giving us written notice of your revocation. Please note that the revocation of this consent will *not* affect any action we took in reliance on this consent before we received your written notice of revocation. We may decline to treat you if you revoke this consent.

SIGNATURE:
I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving consent to your use and disclosure of may protected health information to carry out treatment, payment, and health care operations. **I acknowledge that I have received a copy of the Notice of Privacy Practices.**

_____ _____
Signature of Patient or person responsible for patient Date

Explain reason for not signing form:_____

FAMILY AND PERSONAL HEALTH HISTORY

NOTE: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name: _____ Age: _____ Birthdate: _____ Today's Date: _____

Occupation: _____ Last Physical Exam Date: _____ Phone # : _____

FAMILY RECORD Check condition(s) and relationship of any blood relative who has or has had any of the conditions listed below	MYSELF	FATHER	MOTHER	BROTHER	SISTER	SON	DAUGHTER
Alcoholism							
Allergies							
Anemia							
Arthritis							
Asthma							
Birth Defects							
Bleeding Tendency							
Cancer, tumor							
Colitis							
Congenital Heart							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Goiter							
Hay Fever							
Heart Attack							
Heart Disease							
High Blood Pressure							
Kidney Disease							
Leukemia							
Liver Disease							
Mental Illness							
Nervous Breakdown							
Obesity							
Rheumatism							
Rheumatic Fever							
Sickle-Cell Anemia							
Stomach Ulcer							
Stroke							
Suicide							
Tuberculosis							

OPERATIONS	YES	NO	DATE
Tonsils			
Appendix			
Gall Bladder			
Stomach			
Kidney			
Colon			
Thyroid			
Hernia			
Breast (women)			
Uterus (women)			
Ovaries (women)			
Prostate (men)			
Other: If yes what			

Do you: (if yes, daily comsumpation)	YES	NO	
Smoke (Pkgs.)			
Drink Coffee (Cups)			
Drink Beer (ozs.)			
Drink Hard Liquor (ozs.)			

IMMUNIZATIONS	YES	NO	DATE
Pneumonia Vaccine			
Tetanus			
Booster			
Measles			
Influenza			
German Measles/Mumps			
Other: If yes, what-			

XRAYS	YES	NO	DATE
Last Mammogram			
Back			
Chest			
Colon			
Extremities			
Gall Bladder			
Kidney			
Stomach			

FAMILY MEMBERS- LIVING	AGE	HEALTH (please indicate) G – Good F – Fair P - Poor	FAMILY MEMBERS-DECEASED	AGE OF DEATH	CAUSE OF DEATH
Father			Father		
Mother			Mother		
Brother(s)			Brother(s)		
Sister(s)			Sister(s)		

FAMILY AND PERSONAL HEALTH HISTORY

NOTE: Please complete all information on this record. All information is treated in confidence and will not be released unless you grant permission.

Name :_____

PAST AND PRESENT MEDICAL PROBLEMS

Check all that apply, indicate if present or past and if past give approximate date.	Present	Past	If Past, Date
Asthma			
Angina			
Anemia (Type)			
Arthritis			
Blindness (either eye)			
Broken Bones			
Cataracts			
Chronic Bronchitis/Chronic Lung Disease			
Cirrhosis of Liver			
Colon or Bowel Trouble			
Deafness			
Dysentery			
Diabetes			
Ear Infections			
Emphysema			
Enlarged Heart			
Glaucoma			
Gall Stones			
Gout			
Goiter			
Gonorrhea			
Hay Fever			
Heart Murmur as Adult			
Heart Attack			
High Blood Pressure			
Hepatitis			
Hemorrhoids			
Kidney Infection			
Kidney Stones			
Nervous Breakdown			
Poor Blood Clotting			
Polio			
Phlebitis			
Rheumatic Fever			
Rectal Trouble			
Recurrent Boils			
Stroke			
Stomach or Duodenal Ulcer			
Syphilis			
Skin Disease			
Serious Depression			
Serious Emotional Problems			
Tuberculosis			
Thyroid (overactive)			
Thyroid (underactive)			
Varicose Veins			
Prostate Problems (MEN)			

Check all that apply, indicate if present or past and if past give approximate date.	Present	Past	If Past, Date
(WOMEN)			
Menstrual Difficulties			
Cystitis			
Mastitis			
Ovarian Cyst			
Breast Cancer			
Other Breast Disease*			
Other Gynecological Problems*			
Still Menstruating			

Age Period Started _____
Age Periods Stopped _____
Why Periods Stopped _____
Number of Pregnancies _____
Number of Children _____
Number of Miscarriages _____
*Explain:

Hospitalizations/Reason Date:
Do you ever wear artificial devices? Yes No
Please list
Do you have allergies? Yes No
Please list

Doctor's Use Only-Summary

American Behavioral Clinics, S.C.

American Behavioral Clinics

Patient Care Communication Form
Release of Protected Health Information to Physician

Physician's Name: _____

Physician's Address : _____

City _____ State _____ Zip _____ Phone # _____

Dear Dr.: _____

Your Patient : _____ DOB: _____
Was seen at American Behavioral Clinics.

Date of Initial Assessment: _____

Diagnosis and/or presenting problem: _____

_____

_____

Medication(s): _____

_____

Sincerely, _____ Date: _____

Authorization to Disclose Information

To the Patient: Disclosure of the above information is for the co-ordination of care between your physician and your behavioral health provider(s). The information released on this form is part of your protected health information and is protected by federal law. Releasing this information to your physician is strictly voluntary and does require that your written consent for this form be sent to your physician. It does not allow for any other information to be disclosed nor does it allow for any other form of communication to take place. If you want your physician to receive additional information from your confidential records, a release of information for that purpose can be provided for you.
To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making further disclosures of this information.

Patient to Complete the Following:

_____ **I want this information to be given to my physician.**

_____ **I DO NOT want this information to be given to my physician.**

Patient/Guardian Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Form Originated from the following location:

Bluemound Clinic	*Elmbrook Clinic*	*Southwest Clinic*	*Mequon Clinic*
10424 W. Bluemound Rd.	15285 Watertown Plank Rd.	7330 W Layton Ave.	1240 W Ranchito Ln.
Milwaukee, WI 53226	Elm Grove, WI 53122	Milwaukee, WI 53220	Mequon, WI 53092
(414) 774-1794	(262) 797-2818	(414) 281-1677	(262) 241-3231
Fax: (414) 281-9884	Fax (262) 797-2814	Fax (414) 281-9884	Fax (262) 241-4311
☐	☐	☐	☐