Prime Behavioral Health, LLC

Adolescent, Adult and Geriatric Psychiatric and Psychological Services
13994 Baltimore Ave Suite 102
Laurel, Maryland 20707
(p) 301-477-2128 (f) 301-477-1758

PATIENT INFORMATION FORM

Last Name First Middle Male or Female

Street Address City State Zip

Marital Status Employer Occupation

Home Phone Work Phone Cell Phone Preferred # to confirm appts: H W Cell

SS# DOB Patient Email

Pharmacy Name and Address Pharmacy Phone

MEDICAL INSURANCE INFORMATION

Primary Insurance Identification # Group# Relationship to the Policy Holder

Policy Holder's Name DOB SS#

Policy Holder's Street Address (if different from above) City State Zip

Secondary Insurance Identification # Group# Relationship to the Policy Holder

Policy Holder's Name DOB SS#

Assignment and Release:
I, the undersigned certify that I (or my dependent) have insurance coverage with above listed plan and assign directly to Prime Behavioral Health, LLC (PBH) all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges and will pay the balance if not paid by insurance in the allowed 60 days. I hereby authorize Prime Behavioral Health, LLC to release all information necessary to secure payment of benefits, including the diagnosis and records of any treatment or examination. I authorize the release of this information to third party payers, the physician's/therapist's billing service and/or other health practitioners. I understand that unpaid balances may be turned over to a third party for collection. I authorize the use of this signature on all insurance submissions. I agree that all co-payments will be paid at the time of service, in accordance with the contracted insurance carrier agreement.

Signature Date

Prime Behavioral Health, LLC

Adolescent, Adult and Geriatric Psychiatric and Psychological Services
13994 Baltimore Ave Suite 102
Laurel, Maryland 20707
(p) 301-477-2128 (f) 301-477-1758

The educational notification on our office board provides information about how this office (Prime Behavioral Health, LLC), may use and disclose protected health information about you, and is compliant with the requirements of HIPAA of 1996. Our Notice of Privacy Policy states that we reserve the right to change the terms described. Should this happen, you will be notified on your next visit to our office. You have the right to request restrictions on how your protected health information may be used and disclosed for treatment, payment, or health care operations. We are not required to agree with your restrictions, but if we do, we are bound by our agreement with you. By signing this, you acknowledge receiving our Notice of Privacy Policy.

Consent to Treatment and Patient Bill of Rights

____ I consent to the treatment I am receiving in this office. I also understand that if I have any concerns or questions regarding my treatment or medication, I should address them with my provider(s). I understand that if I am not seen in the office for six months, that my chart will be closed and I will be treated as a new patient.

Consent for Use and Disclosure of Information

_____ I consent to PBH use and disclosure of protected health information for treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where PBH has already made disclosure in trust, based on my prior consent. I authorize any holder of medical information about me to release to Prime Behavioral Health, LLC for the purpose of billing for services provided to me. This includes primary care referrals. I agree to provide valid insurance, all referrals and treatment plans as required by my insurance carrier(s).

____ I authorize the Psychiatrist/Therapist to consult with my Therapist/Psychiatrist and/or Primary Care Physician. The PCP will receive a copy of the psychiatric evaluation if consented.

____

Current Psychiatrist's or Therapist's Name   Street Address   City   State   Zip

(_____)_______________   (_____)_________________

Phone #   Fax #

____

Primary Care Physician's Name   Street Address   City   State   Zip

(_____)_______________   (_____)_________________

Phone #   Fax #

I permit a copy of this authorization to be used in place of the original. ______________________________
This authorization may be revoked by me at any time in writing.   Signature

Missed Appointment Agreement (does not apply to medicare or Medicaid clients)

I agree to give at least 24 hours advance notice if I will not be able to come to a scheduled appointment. I understand that there may be a $25 charge for a missed Medication Management appointment and a $50 charge for Therapy appointments. The same fees apply for any cancellations without 24 hours notice. I realize that I am personally responsible for this charge and that Prime Behavioral Health, LLC will not bill my insurance carrier for it.

____   ____________________

Signature   Date

Prime Behavioral Health, LLC

Adolescent, Adult and Geriatric Psychiatric and Psychological Services
13994 Baltimore Ave Suite 102
Laurel, Maryland 20707
(p) 301-477-2128 (f) 301-477-1758

Authorization for Medical Records

Patient Name: ______________________________ **Birth Date**: ______________

Authorization for the following Provider(s) to release Medical Records:

Name (or title) and organization ______________________________

Address: ______________________ City ______________ State ____ Zip ________

Phone #: ______________________ Fax #: ______________________

Name (or title) and organization ______________________________

Address: ______________________ City ______________ State ____ Zip ________

Phone #: ______________________ Fax#: ______________________

You may release the following health care information:

☐ Medical Treatment Records

You may release the information to:

☐ Prime Behavioral Health, LLC
13994 Baltimore Ave Suite 102
Laurel, MD 20707
(p) 301-477-2128
(f) 301-477-1758

Reason(s) for this authorization (check all that apply):

☐ At my request
☐ Other (specify) ______________________________

____

This authorization ends: ☐ on (date) ______________
☐ when the following event occurs ______________________

______________________ ______________ ______________
Signature (patient or authorized representative) **Date** **Time**

______________________ ______________________
Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)