Behavioral Medicine Specialist, P.A.

7829 E. Rockhill, STE 101

Wichita, KS 67206

Thank you for calling Behavioral Medicine Specialist, P.A. **Please arrive 10 minutes** early with the following:

- ☐ Paperwork
- ☐ Insurance Card(s)
- ☐ Driver's License/Identification card
- ☐ Copay/ Payment for deductibles (**Copay/Payment is due at the time of service**).
- ☐ You will owe the following amount at your upcoming appointment $_____.

If you are more than 15 minutes late, your provider may ask you to reschedule your appointment to a later date. **Please cancel 24 hours in advance** if you are unable to make your appointment. We reserve the right to charge for appointments cancelled or broken without 24 hours advanced notice.

If you have questions, feel free to give our office a call at (316) 686-5195. Thank you!

BEHAVIORAL MEDICINE SPECIALISTS, P.A.

WAYNE A BURNS, LSCSW • LUKE CARTER, PSYD • ADOLPH CHAVEZ, LCMFT • LINDA CRENSHAW, LSCSW
SHERILYN DALKE, LCPC • MARGARET "PEGGY" HERNANDEZ, APRN • MICHAEL D LEAHY, PSYD • MARIAM NJOKU, APRN-BC
MANDI SEACHRIS, LCPC • DEBBIE TRIMMELL-MARTIN, LSCSW

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE)			SOCIAL SECURITY NUMBER / /
DATE OF BIRTH / /	AGE	SEX ☐ M ☐ F	MARITAL STATUS (CIRCLE ONE) SINGLE MARRIED SEPARATED LIFE PARTNER DIVORCED WIDOWED
ADDRESS			CITY, STATE, ZIPCODE
TELEPHONE NUMBER	CELL PHONE	PRIMARY CARE PHYSICIAN	PHYSICIAN TELEPHONE
EMPLOYER	EMPLOYER ADDRESS		CITY, STATE, ZIPCODE
EMPLOYER TELEPHONE	EXTENSION	PATIENT'S EMAIL ADDRESS	OCCUPATION

EMERGENCY CONTACT

NAME:_____ RELATIONSHIP TO PATIENT:_____ PHONE #:_____

BILLING INFORMATION (RESPONSIBLE PARTY) CHECK BOX IF SAME AS ABOVE ☐

RELATIONSHIP TO PATIENT	NAME	SOCIAL SECURITY NUMBER / /	DATE OF BIRTH / /	AGE	SEX ☐ M ☐ F
ADDRESS	CITY, STATE, ZIP		TELEPHONE NUMBER		
CELL PHONE	EMPLOYER	EMPLOYER TELEPHONE	OCCUPATION		

PRIMARY INSURANCE

INSURANCE COMPANY NAME	SUBSCRIBER'S SSN
IDENTIFICATION/ MEMBER NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S EMPLOYER

SECONDARY INSURANCE

INSURANCE COMPANY NAME	SUBSCRIBER'S SSN
IDENTIFICATION/ MEMBER NUMBER	GROUP NUMBER
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT
SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S EMPLOYER

CONSENT FOR TREATMENT: I request that payment of authorized benefits Medicare, Medicaid, and/or any Insurance Carrier listed, be made to Behavioral Medicine Specialists, PA on my behalf for any services furnished to me. I authorize the release of medical information to the listed insurer(s), and/or agents of these companies. I consent to treatment by the staff of Behavioral Medicine Specialists, PA for myself or my child. I understand that I am obligated to pay co-payments, co-insurance and deductibles as required by my health insurance. I also understand that I will be financially responsible for all treatment fees if I fail to keep Behavioral Medicine Specialists, PA informed in writing of changes in my insurance. I understand that all payments are due at the time of service and any outstanding bill will be turned for collections if not paid promptly.

Patient Signature:	DATE
IF UNDER 18, PARENT OR GUARDIAN MUST SIGN BELOW	
Parent/Guardian Signature:	DATE

BMS

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Patient Information for Minors

Names of Parents:

Mother: _____

Father: _____

Parents are (circle one): Married Separated Divorced Single Parent

If parents are separated or divorced, absent parent's address:

_____

_____

Telephone number for both parents:

Mother: Home phone: _____/Cell phone: _____

Father: Home phone: _____/Cell phone: _____

Name of School child attends: _____

Teacher's name: _____

Phone number of School: _____

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BMS

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AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBER

Patient Name _____ Date of Birth_____

Many of our patients allow family members such as their spouse, parents, or others to call and request an appointment, billing or medical information (medical information only applies to medication management and not therapy services). Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your appointment, billing or medical information released to family members, you must sign this form. Signing this form will only allow information to be given to family members indicated below.

I authorize Behavioral Medicine specialists, P.A. to release my appointment, billing and/or medical information to the following individual(s):

1. _____ Relation to Patient _____

2. _____ Relation to Patient _____

3. _____ Relation to Patient _____

Patient information
I understand I have the right to revoke this authorization at any time in writing.

Signature: _____ Date: _____

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www.behavioralmedicinespecialists.com

BEHAVIORAL MEDICINE SPECIALISTS, P.A.
7829 E ROCKHILL SUITE 101 WICHITA, KS 67206
PHONE: 316-686-5195 FAX: 316-686-8714

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

PATIENT: _____ **DATE OF BIRTH:** _____

ADDRESS: _____ **CITY, STATE, ZIP:** _____

AUTHORIZES:

NAME OF HEALTH CARE PROVIDER/OTHER: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

TO RELEASE INFORMATION TO/FROM:

NAME OF HEALTH CARE PROVIDER/OTHER: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PHONE: _____ FAX: _____

INFORMATION TO BE RELEASED:

___PSYCHOLOGICAL TESTING INFORMATION
___VERBAL COMMUNICATION
___WRITTEN COMMUNICATION
___CONSULTATIONS
___MEDICAL HISTORY, EXAMINATION, REPORTS
___TREATMENT OR TESTS
___HOSPITAL RECORDS INCLUDING REPORTS
___PRESCRIPTIONS
___SURGICAL REPORTS
___LABORATORY REPORTS
___ENTIRE RECORD

PURPOSE FOR NEED OF DISCLOSURE:

___ FURTHER MEDICAL CARE
___INSURANCE ELIGIBILITY/BENEFITS
___LEGAL INVESTIGATION OR ACTION
___CHANGING PHYSICIANS
___PERSONAL
___OTHER (SPECIFY): _____

I UNDERSTAND THAT IF THE PERSON(S) AND/OR ORGANIZATION(S) LISTED ABOVE ARE NOT HEALTH CARE PROVIDERS, HEALTH PLANS OR HEALTH CARE CLEARINGHOUSES WHO MUST FOLLOW FEDERAL PRIVACY STANDARDS; THE HEALTH INFORMATION DISCLOSED AS A RESULT OF THIS AUTHORIZATION MAY NO LONGER BE PROTECTED BY THE FEDERAL PRIVACY STANDARDS AND MY HEALTH INFORMATION MAY BE RE-DISCLOSED WITHOUT OBTANING MY AUTHORIZATION. YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION: RIGHT TO INSPECT OR COPY THE HEALTH INFORMATION TO BE USED OR DISCLOSED—I MAY ARRANGE TO INSPECT MY HEALTH INFORMATION BY CONTACTING THE OFFICE AT BMS, P.A. RIGHT TO RECEIVE COPY OF THIS AUTHORIZATION—I UNDERSTAND THAT IF I AGREE TO SIGN THIS AUTHORIZATION, WHICH I AM UNDER NO OBLIGATION TO SIGN THIS FORM AND THAT THE PERSON(S) AND/OR ORGANIZATION(S) LISTED ABOVE WHO I AM AUTHORIZING TO USE AND/OR DISCLOSE MY INFORMATION MAY NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT IN A HEALTH PLAN OR ELIGIBILITY FOR HEALTH CARE BENEFITS ON MY DECISION TO SIGN THIS AUTHORIZATION. I UNDERSTAND WRITTEN NOTIFICATION IS NECESSARY TO CANCEL THIS AUTHORIZATION.

AUTHORIZATION IS GOOD UNTIL: _____ **OR ONE YEAR FROM THE DATE SIGNED.**

SIGNATURE OF PATIENT/LEGAL REPRESENTATIVE: _____ **DATE:** _____

SIGNATURE OF WITNESS: _____ **DATE:** _____

BEHAVIORAL MEDICINE SPECIALISTS
CONFIDENTIAL HEALTH INFORMATION

Patient Name: _____ DOB: _____

Date of Last Physical Examination: _____

What is Your Primary Complaint: _____

_____

_____

Previous Psychological Treatment:

Therapist/Physician:	Reason:	Dates:
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST MEDICAL HISTORY:

Please list any previous Medical Problems, Illnesses, Allergies, Injuries, Surgeries or Hospitalizations:

Date:	Reason:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY MEDICAL HISTORY:

Please list any blood relative related to yourself who has suffered any of the following:

	RELATION:		RELATION:
Allergy:	_____	Hypertension:	_____
Migraine:	_____	Heart Disease:	_____
Ulcers:	_____	Alcohol/Drug:	_____
Epilepsy:	_____	Mental Illness:	_____
Diabetes:	_____	Eating Disorder:	_____
Cancer:	_____	Other (specify):	_____

{CONTINUED ON BACK SIDE}

CURRENT MEDICATIONS

Name of medication:	Dose:	Duration of Treatment:	Prescribed by:

CURRENT PATTERNS OF BEHAVIOR:

Activity:	Yes/No	Type/Frequency:
Do You Smoke?		
Do You Drink Alcohol?		
Do You Take Non-Prescription Drugs?		
Do You Exercise?		
Do You Have a Weight Problem?		
Do You Have Trouble Sleeping?		
Do You Attend School?		
Are You Currently Employed?		

Sex: Male Female

Marital Status: Single Married Divorced
Widowed Common-law Cohabiting

Education:

_____Some Grammar School _____Technical

_____Some High School _____Some College

_____Completed High School _____Completed College

_____G.E.D. _____Post-Graduate Training

PERSON TO CONTACT IN CASE OF A MEDICAL EMERGENCY:

Name _____ Relationship _____ Phone Number/Ext. _____

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NEW CLIENT INFORMATION

Welcome to Behavioral Medicine Specialists. We are a multidisciplinary group of mental health professionals. Each of us is responsible for providing his/her own clinical services and records.

FINANCIAL POLICY

_____
Initials

The mental health provider you are seeing today at Behavioral Medicine Specialists, P.A. has contracted with a variety of insurance companies. We also provide services for private pay clients. We will submit claims, on your behalf, to your primary insurance carrier, as well as, secondary and tertiary carrier (if applicable). Our office does not contract with health share plans, auto, or liability insurance companies. **Payment is required at the time of service.**

Please remember your health insurance is an agreement between you and your insurer. **It is your responsibility to know and understand the coverage, benefits and requirements of your health insurance plan.** If you would like us to submit a claim for your services, you must provide current insurance information prior to the time of service

If your health insurance requires a deductible, co-insurance, or copay, you will be required to pay for that amount in full at the time of service. We accept cash, check, or credit card (Visa, Mastercard, Discover, Amex). If you are not prepared to pay the required amount at the time of service, you will be required to reschedule your visit. Our office reserves the right to refuse to schedule future appointments until the entirety of your bill has been paid.

Our office does not offer long-term financing of balances for healthcare we provide. We also do not offer a sliding fee schedule or provide income-based payment options on your account balances. Limited payment plans may be available (but are not guaranteed) and must be approved by your provider at Behavioral Medicine Specialists, P.A. In the event that your bill is not paid timely and we must employ a collection agency or attorney, all interest and/or fees for collection will be the responsibility of the patient/guarantor in addition to the balance for healthcare services rendered.

CREDIT CARD AUTHORIZATION POLICY

_____
Initials

Our policy requires that a credit card must be saved on file prior to being seen by our providers. **This card will be charged for appointment co-pay, co-insurance, and deductible amounts at the time of service.** Private pay fees will also be collected at the time of service. Additionally, the card will be charged if your account has a balance more than 30 days past due. If you do not provide a debit, credit or health savings card, and a cash payment is not provided prior to being seen by our providers, it may be necessary to reschedule your appointment and it might result in not being able to schedule future appointments until a valid card is saved on file.

The security of your information is of the utmost importance. Your card information is stored by the credit card merchant vendor who specializes in credit card processing and maintains the highest level of security for credit information. Our staff does not have access to your card information after it is entered into the merchant vendor's database. No personal medical information is stored with the credit merchant company.

MISCELLANEOUS FEES AND BILLING

_____
Initials

In addition to our professional fees, you may be charged for phone conversations, writing letters, court preparation and appearance. All FMLA forms are $50.00 to complete (they will not be returned or forwarded until paid in full). It is our policy to charge for appointments that are not canceled 24 hours in advance and for appointments that are not kept. Insurance does not pay for missed appointments. We reserve the right to charge $50.00 for missed appointments, appointments cancelled or broken without 24 hours advance notice may be charged $25.00. Appointments missed because of inclement weather or other major problem will not be charged. Your charge will be applied to your credit card on file.

For any questions regarding billing information, call between 8:30 a.m. and 3:00 p.m., Monday through Thursday.

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PRIOR AUTHORIZATION/NON-COVERED CHARGES

_____ ***Initials***

Managed care plans often require prior notification before they will authorize reimbursement for mental health services. It is your responsibility to make sure prior authorization is in place prior to the date of service. Most plans have exclusions and non-covered benefits. It is your responsibility to know what your insurance plan will cover as outlined in your certificate of coverage.

OFFICE HOURS AND EMERGENCIES

_____ ***Initials***

Office hours vary by therapist. Office hours are 8:00 a.m. to 8:00 p.m., Monday through Thursday and 8:00 a.m. through 5:00 p.m. on Friday. For after hours, our answering service is available at (316) 686-5195. In an emergency, call this number and the answering service will attempt to locate your therapist or an on-call therapist. You may also call your family physician or go to the emergency room at the nearest hospital.

PROFESSIONAL RECORDS/CONFIDENTIALITY

_____ ***Initials***

Both the standards of our profession and the law require keeping appropriate treatment records. If you have questions about or wish to review your records, you are encouraged to discuss this with your therapist. No one has access to your records without your permission unless under the conditions outlined under confidentiality rules.

If you are under 18 years of age, your parents must sign for consent to treatment in our office and are entitled to receive some feedback about your treatment. Usually we provide parents of older children only general information unless there is a significant risk of harm to yourself or others. Any sensitive information that needs to be shared with your parents will be discussed with you first.

The law protects the confidentiality of all communications between a client and mental health provider. With a few exceptions, information about your treatment can only be revealed with your written permission. There are situations, such as a child custody hearing, where a judge may order treatment records be released to the court, and your confidentiality may not be able to be protected. In cases where a child, elderly person, or disabled person is suspected of being abused, we are required by state law to file a report with the appropriate agency. If a client is threatening bodily harm to another, we are required to take protective actions, including notifying the potential victim, notifying the police, or seeking appropriate hospitalization. If a client threatens to harm himself/herself we are also required to seek hospitalization or appropriate protective treatments as well as contact family members who can help.

Your signature below as well as your initials by each section, indicate that you have read and acknowledge this information. *It is your responsibility to seek clarification if you have any questions.*

_____ _____

Client/Parent Signature Date

_____ _____

Witness Date

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