ALLIANCE
MENTAL HEALTH SPECIALISTS

2021 Current Patient Registration Update form

Patient Information: Legal First Name:	Middle Initial:	Last Name	
Date of Birth:	Social Security Number:	Gender:	
Street Address:	City:	State:	Zip Code:

Cell Phone	**Contact Number:**	You may call or text me at my cell phone ☐ Yes ☐ No
Home Phone	**Contact Number:**	You may contact me at my home phone ☐ Yes ☐ No
Email	**Contact Email:**	You may contact me at my email address ☐ Yes ☐ No
	You ☐ may send **un-encrypted** email/documents. **This email address will also be used for your patient portal access.** You may be emailed the following information: - General inquiries (i.e. appointments, requests, etc.) - Reports, treatment plans, etc. related to treatment which includes specific details about my mental health and/or treatment.	

I authorize Alliance Mental Health Specialists to communicate confidential information to me by the means indicated above.

Client Signature: _____

Emergency Contact Name:	Phone Number:	Relationship:
Pharmacy Name and nearest Cross Streets:	Phone Number:	Fax Number:

Authorization for Release of Information / Confidentiality Form

I authorize the following individuals and or agencies to access, use or disclose information in my health record or appointment history.

Requests for copies of medical records are subject to reproduction fees in accordance with federal / state regulations. Using the patient portal (patientonlineportal.com) is a free service provided by AMHS (Alliance Mental Health Specialists). See staff for instructions.

2. Authorizing this release of information is voluntary and I may refuse to sign this document.

3. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.

4. I have the right to revoke this authorization at any time. Revocation must be made in writing and presented to the office.

Revocation will not apply to information that has already been disclosed in response to this authorization.

5. The information disclosed pursuant to this authorization may be subject to re-disclosure and therefore no longer protected by federal privacy regulations.

Name/Agency_____Phone_____

Name/Agency_____Phone_____

Verbal/Appointments ☐ Medical Records ☐ Written (Email) ☐

2020 Current Patient Registration Update form continued:

Office and Medication Policy

1. Appointments:
    a. Appointments more than 15 minutes late will be rescheduled depending on availability for that provider, and for that day.
2. Behavior
    a. Appropriate attitude, language and behavior must be displayed at all times from patient, staff and providers.
3. Refills
    a. No refills will be allowed without an appointment. Emergency temporary refills are given on a case by case basis based on provider discretion. If you have not been seen in over 60 days, refills will be denied.
4. Prior Authorizations
    a. Prior Authorizations require 3-5 business days. Approval is based on your insurance policy and not guaranteed for approvals.
    b. Prior Authorizations will only be started once the request has been received by the pharmacy
5. Medication Changes/reactions
    a. All medication changes and reactions require appointments. Please call for immediate appointment.
    *If you are having an severe reaction, please go to the nearest urgent care or call 911.
6. Office Business and After Hours
    a. Current business hours are Monday through Thursday from 9:30 AM to 6:30PM Fridays 9:30 AM to 4:30 PM
    b. See staff about Saturday clinic hours.

Failure to abide by these rules and regulations will result in termination of care. By signing below, you agree to the terms set above and in the full registration packet.

Patient Name _____ Date of Birth _____

Patient Signature _____ Date_____