Date:

ALLIANCE
MENTAL HEALTH SPECIALISTS

Patient Registration

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

Alliance Mental Health Specialists complies with HIPAA and other privacy or security laws and standards regarding the access, use, or disclosure of protected health information (PHI) or electronic protected health information (EPHI). Alliance Mental Health Specialists requires your consent to communicate your confidential information through electronic means (i.e. telephone, email, etc.). Please check the appropriate boxes and provide contact information if you agree. You may opt out of these communications at any time.
The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Cell Phone	You may call or text me at my cell phone ☐ Yes ☐ No	:
Home Phone	You may contact me at my home phone ☐ Yes ☐ No	:
Email	You may contact me at my email address ☐ Yes ☐ No	:
	You ☐ may send un-encrypted email/documents. 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. This email address will also be used for your patient portal access.	

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/Cross Streets:	Phone Number:	Fax Number:
Primary Care Physician:	Phone Number:	Fax Number:

Employment Status: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Full-Time Student ☐ Part-time Student

If employed or attending: Employer Name: _____ Occupation: _____

Race/ Ethnicity (Please Check all that apply):

☐ America Indian or American Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian or Other Pacific Islander

☐ Hispanic/Latino or Other Spanish Origin ☐ White/Caucasian ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed **Preferred Language:** ☐ English ☐ Spanish

Religion: ☐ Agnostic ☐ Atheist ☐ Christian: _____ ☐ Hindu ☐ Jewish ☐ Muslim ☐ Other: _____

Referred By: _____ **Phone #:** _____

Date:

ALLIANCE
MENTAL HEALTH SPECIALISTS

General Consent for Care and Treatment Form

Patient Name: _____ Date of Birth: _____

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary evaluation and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a psychiatrist, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical or psychiatric evaluation, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Witness Name Printed	**Employee Job Title**
Signature of Witness	**Date**

Date:

ALLIANCE
MENTAL HEALTH SPECIALISTS

PATIENT CONSENT FOR FINANCIAL COMMUNICATIONS

PATIENT NAME_____ **DATE OF BIRTH**_____

1. _____(Patient or Guardian Initials)

Financial Agreement.

- I acknowledge, that as a courtesy, Alliance Mental Health Specialists may verify insurance benefits and may bill my insurance company for services provided to me.
- I agree to pay for services that are not covered or covered charges not paid in full including, but not limited to any copayment, co-insurance and/or deductible, or charges not covered by insurance.
- I understand that there is a fee for returned checks.

2. _____(Patient or Guardian Initials)

Third Party Collection. I acknowledge that Alliance Mental Health Specialists may utilize the services of a third party business associate or affiliated entity as an extended business office ("EBO Servicer") for medical account billing and servicing.

3. _____(Patient or Guardian Initials)

Assignment of Benefits. I hereby assign to Alliance Mental Health Specialists any insurance or other third-party benefits available for health care services provided to me. I understand Alliance Mental Health Specialists has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Alliance Mental Health Specialists, I agree to forward all health insurance or third-party payments that I receive for services rendered to me immediately upon receipt.

4. _____(Patient or Guardian Initials)

Medicare Patient Certification and Assignment of Benefit. I certify that any information I provide, if any, in applying for payment under Title XVIII ("Medicare") or Title XIX ("Medicaid") of the Social Security Act is correct. I request payment of authorized benefits to be made on my behalf to Alliance Mental Health Specialists by the Medicare or Medicaid program.

5. _____(Patient or Guardian Initials)

Consent to Telephone Calls for Financial Communications. I agree that, in order for Alliance Mental Health Specialists, or Extended Business Office (EBO) Servicers and collection agents, to service my account or to collect any amounts I may owe, I expressly agree and consent that Alliance Mental Health Specialists or EBO Servicer and collection agents may contact me by telephone at any telephone number, without limitation of wireless, I have provided or Alliance Mental Health Specialists or EBO Servicer and collection agents have obtained or, at any phone number forwarded or transferred from that number, regarding the services rendered, or my related financial obligations. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

6. _____(Patient or Guardian Initials)

A photocopy of this consent shall be considered as valid as the original.

Patient/Patient Representative Signature:

_____ Date:_____

Date:

ALLIANCE
MENTAL HEALTH SPECIALISTS

Patient HIPAA Acknowledgement and Consent Form

Patient Name: **Date of Birth:**

_____ (Patient/Representative initials) **Notice of Privacy Practices**

I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ (Patient/Representative initials) **Release of Information**

I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your

Date:

family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

_____ (Patient/Representative Initials) I wish to designate the following individual to pick up a prescription order onmy behalf:

Name: _____ Date: _____

Name: _____ Date: _____

_____ (Patient/ Representative Initials) I do not want to designate anyone to pick-up my prescription order.

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

Patient/Guardian/Patient Representative Name (Printed) _____

Patient Name (Printed): _____ **Date of Birth:** _____

ALLIANCE
MENTAL HEALTH SPECIALISTS

www.AllianceMHS.com
info@alliancemhs.com
4270 South Decatur Blvd.,
Suite B6, Las Vegas, NV 89103
(702) 485-2100
Fax (702) 825-0091

Medication Policy

If you are prescribed medication during your care and treatment, there are several guidelines which you *must follow.*

1. The medication given to you should be taken as prescribed by your doctor. The medications may not be used for any other purposes than that for which they were given to you. These medications may not be given or sold to **any** other individual.
2. You will be given a specific amount of medications to last a specific length of time. **You must keep track of your medications to make sure you do not run out before the specific time.** It is **your responsibility** to make sure you do not run out before the specified time. It is **your responsibility** to have follow-up appointments scheduled far enough in advance, so you do not run out of medications. Our schedules are usually booked 2 weeks out. We generally **do not** have same day appointments.
3. If the medication you're prescribed requires a Prior Authorization. This process may take a few days. It is a necessary process initiated by your insurance company. It generally takes 3-5 business days to process. There is no need to continuously call the pharmacy and our office as we work closely with the pharmacies and insurance companies to get the medications approved in a timely manner.
4. Requests for medication refills will only be considered during regular office hours. No refills will be given after regular business hours, on weekends or on holidays. In addition, please be advised: No refills are processed on Friday afternoons.
5. Requests for medication refills should be initiated through your pharmacy first who will in turn contact our office. **Please allow 48 hours for this process. If you have not been seen in over 60 days, your request must be reviewed by your provider and may be denied until you are seen.**
6. No new refills or medication changes will be given if you have not been seen in more than 3 months. It is your responsibility to make a follow-up appointment with our office.
7. If the medications prescribed are **not working**, **you will need to be seen** in order for the provider to make any changes.

8. If you call for medication or refills outside of our regular office hours, you will be instructed to go to the nearest emergency room. There you will be evaluated by an emergency room physician who will decided if they can refill your medications or not. Emergency room regulations on medications are very strict and there is no guarantee that you will get your refill.

Breaking these rules may be grounds for your termination of your treatment in our office.

Please read and sign below that you understand and accept the policies outlined above regarding the medications you have been prescribed.

Signature_____ Date:_____

Printed Name_____

Staff Witness_____