HUMAN BEHAVIOR INSTITUTE

Full Service Behavioral Health

PATIENT REGISTRATION FORM – ADULT

HBI USE

Account #: _____

Insurance: _____

EAP: _____

HBI USE

Date:

Patient's Name: (Last Name) (First Name) (Middle)

SSN: _ _ _ - _ _ - _ _ _ _

Date of Birth: MM / DD / YYYY

Gender: ☐ Male ☐ Female

Home Address: (Street No.) (City) (State/Zip)

Mailing Address:
(if different from above) (Street No.) (City) (State/Zip)

Home Phone: ( )

Mobile Phone: ( )

Work Phone: ( )

E-mail:

Preferred way of communication:
(Check all that apply)
☐ Mail ☐ Home Phone ☐ Cell Phone ☐ E-mail

Preferred phone to use for reminders, follow-up, emergencies: ☐ Home ☐ Mobile ☐ Work

Best time to call: ☐ AM ☐ PM

Primary Insurance:

Secondary Insurance:

Main Insured Person:

Main Insured Person:

Referral Source:

If this is a mandatory referral (EAP), who should we contact?

Primary Care Physician:

Phone:

Would you like us to share your treatment information with your Primary Care Doctor? ☐ Yes ☐ No

Have you had previous behavioral/mental health treatment? ☐ Yes ☐ No If yes, when?

Name of Clinician/Facility:

Emergency Contacts
Name:

Name:

Relation:

Relation:

Main Phone: ( )

Main Phone: ( )

Reason for today's visit and what you hope to accomplish at the end of today's visit:

HBI abides by the regulations under the Health Insurance Portability and Accountability Act of 1996 HIPAA and State of Nevada statutes on releasing medical records.
Patient records are maintained pursuant to the Nevada Administrative Code (NAC) 629 and the Nevada State Board of Health.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In order to coordinate my care and process my insurance claims, I authorize the release of medical information to my physician, primary care provider and insurance company. I also authorize the release of information to the following:

1. Authorized Person: _____ Relation: _____
2. Authorized Person: _____ Relation: _____
3. Authorized Person: _____ Relation: _____

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

If this form is being submitted electronically, enter the full name of the signer.

CONFIDENTIALITY: We will be keeping records on the services we have rendered. You may look at your file at any time. While the record is ours, you control the information therein. Should you wish to release any information to a third party, you will need to sign a consent and pay for copying your file. The material you discuss in therapy is personal and confidential. However, there are some situations when information may be shared without your consent. Those reasons are as follows:

1. Potential danger (to self or others).
2. Child and elderly abuse, physical abuse, emotional and physical neglect.
3. Child custody - (court ordered only).

ADVANCE DIRECTIVES

Do you have an Advance Directive? ☐ Yes ☐ No
If yes, please provide a copy to HBI for your treatment record.

ASSIGNMENT OF INSURANCE BENEFITS

I authorize payment of medical insurance benefits to the undersigned clinician or supplier for the services described. Payment is herein directed, in whole or in part, and shall be the same as or if paid to me.

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

FINANCIAL AGREEMENT

The undersigned hereby agrees that in consideration of services to be rendered, the patient or legal guardian individually, jointly, and severally obligates himself, herself, or themselves to pay the account of Human Behavior Institute Clinical Services. The agreed upon fees are as stated on the summary of benefits or charges given to me this day.

I understand that financial obligation is my/our responsibility as the patient/guardian and should the insurance company deny payment or I/we default on payment arrangements, the undersigned agrees to pay reasonable attorney fees and collection expense should the account be referred to a third party for collection.

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

LEGAL MATTERS

HBI does not provide professional legal evaluations or testimony for any legal matters. In the event your therapist is subpoenaed by the legal system, you/your legal representative will bear the cost for such services. **Your insurance does not cover legal professional testimony or depositions.** The cost for such services is $250.00 per hour with a two hour minimum. You/your legal representative need to make financial arrangements with the HBI business office in case this occurs.

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

CONSENT FOR TREATMENT

I have read the materials presented in this disclosure statement and the accompanying brochure. My signature indicates that I understand the information, agree with the conditions of therapy that are stated here and in the Patient Guide, and I commit myself or my minor child to compliance with them.

I understand that once therapy begins, I retain the right to withdraw consent to participate in therapy at any time that seems appropriate. I will make every effort to discuss my concerns about progress of therapy with HBI before I terminate in this manner.

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

Witness Signature:_____ **Date:**_____

☐ **By entering your name on the signature line and checking this box, you certify that you are legally responsible to sign and submit this document electronically.** SAVE THIS DOCUMENT TO YOUR DEVICE, ATTACH IT TO E-MAIL & SEND TO INTAKE@HBINETWORK.COM.