

Altahir Behavioral Health

Informed Consent to Treatment

Patient's Rights and Responsibilities

I understand that treatment offers no guarantees. By working with my provider, I can get help with the problems and concerns that I bring. I understand that I will benefit of treatment in proportion to the effort, dedication, and willingness to participate in sessions, I will not limit myself to only in office efforts. I understand that the effectiveness of treatment can be limited.

I agree to cooperate with my provider or discuss with them why I am unable to. I agree to ask any questions I may have regarding my treatment and the goals that I, along with my provider have set to reach peak wellness.

I understand that treatment will end if I am no longer willing to accept the treatment given by my provider. I also understand that I can, at any point in time, end the doctor patient relationship if I am unsatisfied with the level of care or effectiveness.

Patient Name:

Guardian Name:

Patient Signature:

Guardian Signature:

Altahir Behavioral Health PLC. Office Policies

As a growing practice, it is our goal at Altahir Behavioral Health to serve you in a caring and professional manner.

We feel it would be helpful to help make you aware of the following:

Initial after reading each statement

___ We expect our staff, patients, parent(s)/guardian(s) to respect each other. If threats or foul language is being used against our practice or staff, patient will automatically get terminated.

___ Confidentiality is very important part of treatment. Please know that NO information will be released to any persons that do not have prior consent from the patient or guardian.

___ It is important that patient's (18+) or parent/guardian's responsibility to **update** the practice if any changes of the following: ***contact information, active insurance(s) card, consent to release information, or any records.***

___ All late, canceled, and missed appointments are subject to a **\$50.00 fee**. We require **24-hour notice** to be given. This charge will be due at your next appointment.

___ If two or more appointments are missed in a 12-month period Altahir Behavioral Health will discontinue medication management services.

___ All co-pay, deductibles or any amount not covered by your insurance company will be expected at the time of your appointment.

___ Billing cycles are 45 days after the date of service. Statements are available to be requested at any time. If questions/concerns arise, you may contact our billing department 703-828-6586.

___ You may call our office or send a check to:

Altahir Behavioral Health
239 Garrisonville Rd. Ste. 201
Stafford, VA 22554

___ An account that is greater than \$300 outstanding balance won't be scheduled until 15% is paid towards the balance. Payment plans are available under the Office Manager's discretion.

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date

Altahir Behavioral Health PLC. Office Policies (cont.)

It is our goal at Altahir Behavioral Health to serve you in a caring and professional manner. We feel it would be helpful to help make you aware of the following:

Initial after reading each statement

___ If the patient needs medication refill and verified by the pharmacist, you or the pharmacy may contact our office.

___ Please allow 48 hours for provider's response of refill request to be sent to your pharmacy and 72 hours for prescription Prior Authorization completion.
(Contact us two weeks in advance before medications run out)

___ If appointments are not kept according to your provider's recommendation, no refills can be issued until you are seen for your next follow-up appointment.

___ There are **no refills for controlled medications** if the patient has not been seen for **more than 90 days** (3 months).

___ You are subject to charge if a prescription is lost or misplaced.

___ Altahir Behavioral Health will not release a prescription without proper identification of a party listed on the Consent to Disclose Information Form.

___ Follow up care is very important to both you and your doctor. It is a responsibility by the patient (18+), guardian/parent to schedule. Being compliant with your appointments enables us to refill your medication in a timely manner.

___ Any medical records authorization request requires practice form to be completed with patient's (18+) or parent/guardian's signature. The law allows Medical Offices **30 days** to complete the requested. However, we will put forth every effort to respond to these requests in a timely manner.

___ If you would like to keep a copy of our Office Policies, please ask receptionist. We encourage you to keep a copy for your records.

In signing below, I am stating that I fully understand the Office Policies stated above and that if I have any question they were explained to my satisfaction.

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date

ATTENTION PATIENTS

EFFECTIVE IMMEDIATELY

**ALTAHIR BEHAVIORAL HEALTH PROVIDERS WILL NO LONGER BE
PRESCRIBING ANY:**

BENZODIAZEPINES

A list of Benzodiazepines drugs are:

Klonopin (Clonazepam)

Xanax (Alprazolam)

Librium (Chordiazepoxide)

Valium (Diazepam)

Ativan (Lorazepam)

Doral (Quazepam)

Halcion (Triazolam)

Rohypnol (Flunitrazepam)

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date

Consent to Release/Disclose Health Information

Patient Name: _____ DOB: _____

I hereby request that health information be discussed with and disclosed to the family member, school official, or friend listed below. The identified below are involved in my/my child's care and agree that the provider listed above may share such information as the provider deems relevant to such individual's involvement, including appointment times, required care, prescription release and diagnosis. I understand that I have the right to revoke this consent release by delivering written notice to the provider.

Please list the Individual's legal name and Relationship to the Patient:

Name:	Relationship (Contact number/email (optional)):
_____	_____
_____	_____
_____	_____
_____	_____

Please note that we will not make appointments, release information, or prescriptions to any person not named on this form. If there are no individual provided, please leave it blank and sign below.

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date

Altahir Behavioral Health PLC

I, _____ consent to:

Text message and Reminders

Phone Call Reminders

Email Reminders

Printed Name of Patient/Guardian

Signature of Patient/Guardian

Date