Avenues for Change

REGISTRATION FORM

(Please Print)

Today's date:	Church Attending:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Parent/Guardian:	Patient Birth date: / /	Age:	Sex: ❑ M ❑ F

Street address:	Email address.:	Home phone no.: ( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.: ( )

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to staff.)

Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )

Is this person a patient here? ❑ Yes ❑ No

Occupation:	Employer:	Employer address:	Employer phone no.: ( )

Is this patient covered by insurance? ❑ Yes ❑ No

Please indicate primary insurance ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ [Insurance] ❑ Welfare *(Please provide coupon)* ❑ Other

Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the assigned clinician to submit necessary PHI for insurance company and to release any information required to process my claims.

_____ _____

Patient/Guardian signature *Date*

Avenues for Change
809 S Patton Rd
PO Box 1223
Great Bend, KS 67530
620-792-2206

Informed Consent

Welcome to Avenues for Change, we are a group of independent licensed therapists ready to serve you and/or your family's mental, emotional and spiritual needs. We are very blessed you have chosen to find peace and healing as well as practical solutions and skills needed to be successful in your personal journey.

As with any personal growth there are risks to consider prior to engaging in services:

Avenues for Change utilizes traditional cognitive, solution-focused, behavior modification, and experiential therapy techniques in addition to traditional talk therapy to meet individual or family needs. You and your therapist will determine the best form of treatment for you and your family. Typically the program we offer consists of twelve weekly sessions. Therapists will discuss and process with you the observations, interactions, emotions, and expectations of each session. As with any treatment, some risk is involved. Emotional and behavior as well as physical symptoms can appear and/or change as you progress in treatment. Please discuss each and every change with your therapist and/or your physician.

Avenues for Change may not provide 24 hour emergency services, if you or a family member is a danger to themselves or others please contact law enforcement and the procedures they have in place for further assessment. However, please contact us during regular business hours for immediate assistance and/or referral for supportive services.

PAYMENT FOR SERVICES: Avenues for Change will not accept any payments for service as each individual therapist will bill and accept payments, which will be discussed with you at intake. However, each therapist will generally accept cash, checks, and has the ability to accept credit card or debit card payments. Please talk to staff about options. Scholarships for services will be available, please talk to your therapist for options if it is difficult for you to pay for services. In the event you have a person or group that can sponsor services, please have them contact the therapist to make payment arrangements. No personal information will be given about progress or attendance, unless a release has been signed authorizing such.

In the event you would like insurance billed, we will do that for you. Co-pays are expected as outlined by your insurance provider. Statements will be provided as requested as you will receive an EOB from your insurance carrier. If primary insurance does not cover your services and you are having difficulty paying please contact staff to make payment arrangements.

MINOR PARTICIPANTS: Any age can receive benefit from the services provided and are welcome to participate; however, every minor referred will be required to have a parent/guardian participate in order to facilitate the therapeutic process and support ongoing growth. However, as parents/guardians of minors being seen; our obligation is to the child and will share necessary information, deemed by the therapist, or information mandated by law. Additionally, if you bring small children not directly involved in the therapeutic process, please know Avenues for Change is not a “safe area” for children to play and you are fully responsible for the safety and maintenance of them while you are at our office.

Missed appointments: In the event you can’t make your scheduled appointment please contact to notify us of your absence. Your therapist may accept email, text and phone notification for absences or other changes. Email is HIPPA secure; however, texting cannot be guaranteed secure, therefore, please don’t text personal information. If you choose to no show for 2 appointments, then your time slot may be forfeited without notification and you will go back on the waiting list or an alternative time slot may be sought. Additionally, you may be charged for each no show appointment at $25/session.

Returned Checks: Checks returned to us by your banking institution for insufficient funds will be charged an additional $30 service fee.

WEATHER CONSIDERATIONS: Avenues for Change will operate in all weather conditions except if the USD 428 school district is closed or tornado warnings have been issued for our area. Otherwise, unless you feel it beneficial for you and your family to not attend. Contact the office if you intend to cancel your appointment.

We are extremely grateful you have shared your lives with us and are very thankful God has given us this gift to offer. By the grace of God, the staff at Avenues for Change is committed to serving you and your family and prays for your successful accomplishments of goals and healing. Please don't hesitate to ask questions or communicate with any staff member regarding any feedback.

Participant/Legal Guardian Date

Therapist Date

Avenues for Change
HIPAA

Name of Provider or Organization: ____Avenues for Change__ Date Updated: 1/25/2019

Address:_____ 809 S Patton, PO Box 1223, Great Bend, KS 67530___

Phone & Email:_____620.796.2206 or info@a4change.org_____

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully***.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations.
- We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/**.
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share.

If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures

How do we typically use or share your health information?

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research.
We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.

Help with public health and safety issues

- We can share health information about you for certain situations such as:
- Preventing disease

- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research
- We can use or share your information for health research.

Comply with the law
- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests
- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director
- We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests
- We can use or share health information about you:
- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions
- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Person Responsible for HIPAA Notification: ____Each independent clinician_____

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This document is to be signed by a person legally responsible for the patient's medical decisions relative to the treatment situation.

I, _____, hereby acknowledge that __Avenues for Change__ has either offered me or provided me with a copy of the Notice of Privacy Practices that describes how medical information about me may be used and disclosed, and how I can access this information.

I understand that if I have questions or complaints I may contact: __Kelley Johnson___

I also understand that I am entitled to receive updates upon request if _Avenues for Change__ amends or changes the Notice of Privacy Practices in a material way.

_____

Signature Relationship to Patient, if signed by someone other than patient

_____

Date

Names of Patients:

_____

IF SIGNATURE OBTAINED FROM PERSON OTHER THAN A LEGALLY RESPONSIBLE INDIVIDUAL, ACTION TAKEN TO OBTAIN LEGAL SIGNATURE

- Given to above signee
- Sent home via U.S. Mail
- Advised person bringing in patient that policy is available on our website

*Website address:*____avenuesforchange.org____

In either situation the parent/legal guardian must sign and return this form either in person or by mail to: ___809 S Patton, PO Box 1223, Great Bend KS 67530 Attn: HIPAA Contact.

THIS SECTION IS TO BE COMPLETED BY MENTAL HEALTH PROVIDER

I made a good faith effort to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

( ) Patient declined to sign this Written Acknowledgement.

( ) Other (specify):

_____

_____ _____

Name and Title Date