



The
Jackson Center

for Behavioral Health & Mental Wellness
198 Narrows Drive Ste. 105, Birmingham, AL 35242

Patient Name		DOB	Gender	Date
Address			Patient SSN	
Home Phone		Cell Phone		
Email Address				
Emergency Contact		Phone	Relationship	
Responsible Party Information (Patient statement will be sent here)				
Name		DOB	Phone Number	
Social Security Number		Relationship		
Address <input type="checkbox"/> check if same as above		City	State	Zip
I am responsible for all charges for all services provided by providers at The Jackson Center, LLC				
Responsible Party Signature			Date	
Insurance Information				
Primary Insurance		Secondary Insurance		
Policy Number	Group Number	Policy Number	Group Number	

Insurance Telephone Number		Insurance Telephone Number	
Name of Insured	DOB	Name of Insured	DOB
Relationship to Patient	SSN of Insured	Relationship to Patient	SSN of Insured
<p>I hereby authorize The Jackson Center, LLC, to: 1) furnish my insurance company with any/all information requested concerning my/my dependent's present claim(s), including records if requested, 2) bill my insurance company and accept payment from that company on my behalf for all services relating to my care. I acknowledge that I am responsible for all charges not covered by my insurance. Any money credited as overpayment due to me will be refunded after completion of treatment.</p>			
_____ Primary Insured Party Signature		_____ Date	

Policies and Procedures Agreement

Please indicate that you have read each section by initialing as designated OR by choosing statements most appropriate for you when specified.

Office Hours and Appointments

We provide service by appointment only, Monday through Thursday, 8:00 a.m. to 5:00 p.m. and Friday 8:00 a.m. to 12:00 p.m. Appointment lengths vary based on type (initial or follow-up).

Telephone Service

The phones are answered from 8:00 a.m. to 4:30 p.m. Monday through Thursday and 8:00 a.m. to 11:45 a.m. on Friday. If you leave a message, every effort will be made to have one of the office staff return your call the same day. Messages left on the weekend will be returned by office staff on the following business day.

As a rule, our providers are scheduled to see clients the majority of the day and do not take phone calls. Front office staff will return phone calls during regular business hours and communicate information between provider and patient.

Emergency Access

Our office is not equipped to handle emergencies. In the event of an emergency, please call 911 or go to your nearest emergency room. Below are other resources that can help during emergencies.

- 24 Hour ~ 7 Day Emergency Mental Health Resources**
- | | |
|---------------------|----------------|
| 24 hour Crisis Line | 1-800-681-7444 |
| Adult Mobile Crisis | 1-855-274-7471 |
| Youth Mobile Crisis | 1-866-791-9226 |

Copies of Medical Records

All requests for medical records should be directed to office staff. A minimum \$20 fee will be charged for patient requests. All requests will be fulfilled within 10 business days unless circumstances do not permit (e.g., illness, vacation, etc.).

A valid signed consent form has to be on file before records are released to anyone other than the patient (or parent/guardian).

Initial here: _____

24 Hour cancellation and "No Show" Fee Policy

Consistent attendance is an integral part of the treatment process. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, The Jackson Center will charge a fee of \$100 for all initial appointments that are missed or canceled with less than 24 hours' notice. For follow-up appointments, a \$25.00 fee will be charged for the first occurrence and a \$50.00 fee will be charged for all subsequent occurrences. These fees will be billed to the patient, are not covered by insurance, and must be paid prior to scheduling your next appointment. Multiple no shows may result in termination from our practice. Additionally, it is understood that if a patient is more than 10 minutes late for an appointment, that patient may be required to reschedule the appointment.

Use of Voicemail, Email and Text

Staff at The Jackson Center will leave voice messages as a courtesy when confirming appointments, if an appointment needs to be rescheduled, for billing and insurance purposes, or to relay a message from a provider.

Please initial the statement below that is appropriate for you:

_____ Yes, voicemail can be used as a way to communicate the above information.

_____ No, voicemail cannot be used as a way to communicate the above information.

Some individuals prefer to use email communication regarding client needs (e.g., scheduling appointments, contacting clinic providers, relaying messages to a provider). Even though all emails sent through The Jackson Center are sent with a confidentiality message, email is not considered a secure communications medium. If you choose to use email as a medium for communication, The Jackson Center and undersigned provider do not guarantee privacy will be maintained through the chain of communication between us.

Please initial the statement below that is appropriate for you:

_____ Yes, email can be used as a way to communicate the above information.

_____ No, email cannot be used as a way to communicate the above information

The Jackson Center may send automated appointment reminders via text message. Text messaging is not considered a secure communication medium

Please initial the statement below that is appropriate for you:

_____ Yes, text messaging can be used as a way to communicate the above information.

_____ No, text messaging cannot be used as a way to communicate the above information

Initial here: _____

General Privacy Policy

In general, the law protects the privacy of all communications between patient and psychiatric nurse practitioner. However, certain situations may require the disclosure of a patient's treatment to prevent harm. Some examples include:

- Threats of self-harm: We are legally obligated to ensure a patient's safety by seeking hospitalization or contacting friends or family who can provide protection.
- Threats of serious harm to others: We are legally obligated to warn the potential victim(s) and law enforcement.
- Reasonable suspicion of elder or child abuse and/or neglect: We are legally obligated to notify the appropriate state agency.

Child And Adolescent Privacy Policy

The same safety and privacy policy extends to children and adolescents. It is our policy to keep parents involved in treatment, with the understanding that the child or adolescent is able to express what they want to be shared. This will not always direct treatment, but to ensure the creation of a safe space for younger individuals, their input will be considered. If there is an immediate safety concern, the parent/guardian will be promptly notified.

Initial here: _____

Students and Interns in the Clinical Environment

The Jackson Center is a teaching clinic. That means nurse practitioner and physician assistant students who are obtaining their required clinical hours for an accredited graduate degree are frequently present for patient appointments. At times, the student may be observing and other times they may be leading the appointment and reporting to the provider. Please advise the front office if you prefer to be seen without a student present during your appointment.

Initial here: _____

Consent for Treatment

I authorize my provider to carry out diagnostic evaluation and treatment for myself or my dependent. I understand that these treatments and their purpose will be explained to me during my/my dependent's appointment time. I also understand that, while the course of my treatment is designed to be helpful, the provider can make no guarantees about the outcome of these treatments and that these treatments, especially medications, may also pose risks. Medication may have unwanted side effects in spite of being a legitimate treatment for my/my child's diagnosis. In all cases, these treatments and any unwanted effects will be discussed and resolved between the provider and me/my dependent.

I have read and understand the above information. I consent to participate in evaluation and treatment offered by The Jackson Center. Furthermore, I understand that I may stop this treatment at any time, but will discuss this with my provider first to avoid any risks associated with the discontinuation of medications.

Patient Name (Printed)

Patient or Legal Guardian Signature

Date

Financial Policy Agreement

Acceptance and Submission to Insurance Companies

As a service and courtesy to the patient, staff at The Jackson Center will bill insurance companies and other third-party payers, but cannot guarantee such benefits or the amounts covered, and are not responsible for the collection of such payments. In some cases, insurance companies may not consider certain services medically necessary or may determine that certain services are not covered by your policy (or require preauthorization before the services can be offered).

In such cases, the Responsible Party listed below is responsible for payment of these services.

Insurance deductibles, co-insurance, and co-payments are due at the time service is rendered. All insurance benefits will be assigned to The Jackson Center unless the Responsible Party pays the entire amount of services at each visit.

I authorize The Jackson Center to disclose case records (including but not limited to diagnosis, progress notes, treatments, and/or other requested information) to my third party payer or insurance company for the purpose of claims processing and receiving payment directly to The Jackson Center. I consent that The Jackson Center may discuss with or release billing/insurance information to my insurance company or third party provider. I understand that access to this information will be limited to determining insurance benefits and will be accessible to persons whose employment is to determine payments and/or insurance benefits

I understand that there will be a \$25.00 returned check fee for any check written for services and returned by my financial institution. This fee is in addition to any fees charged by my financial institution and will be paid in cash to The Jackson Center

Responsible Party Name (printed)

Date

Responsible Party Signature

Controlled Substance Prescribing and Urine Drug Testing Policies
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Controlled Substance Prescribing Policy

The controlled substance policy regards the use of controlled drugs. These drugs are categorized by the Drug Enforcement Agency (DEA) as category 2, 3, and 4. These medications are categorized as controlled substances because of their potential for addiction and/or abuse. They are closely regulated and monitored by authorities. These drugs include, but are not limited to, opiates, benzodiazepines, stimulants, and hypnotics (sleep medications). Misuse of them by either patient or prescriber results in serious penalties under the law.

The policy on these medications is based on the following:

- Controlled drugs can be useful in helping people if used with caution.
- When misused, controlled drugs cause harm that far exceeds their usefulness.
- Controlled drug abuse is common, and these drugs are commonly trafficked illegally.

The dangers of controlled drugs include:

- Dependence – when a person develops a tolerance to the drug over time, requiring progressively higher doses to get the same effect, and when abrupt stopping of the drug causes significant withdrawal symptoms.
- Addiction – when a person uses the drug compulsively and uncontrollably.
- Impaired mental status – can cause falls in the elderly, dangerous behavior, and impaired driving.
- Overdose – many of these drugs are dangerous or even fatal if taken in excess or in combination with other drugs/alcohol.
- Long term consequences – Long term use of these medications is associated with a variety of problems. Recent data, for example, point to an increased risk of Alzheimer’s in people taking long-term anxiety medications.
- Legal consequences – selling, sharing, or illegally possessing these drugs is considered a felony offense.

The medications included in this policy that are prescribed by this office include:

- Benzodiazepine (anxiety) medications, which are meant to be taken, whenever possible, on either a short-term basis, or an intermittent as-needed basis. They are not meant, in general, for daily use. Long-term use of these medications should be done with great caution and high supervision. Regular efforts should be made to decrease chronic dosage whenever possible. Those requiring regular use of these

medications will be encouraged to find other treatments that are safe for daily, long-term use and/or psychotherapy to decrease the need for such medication.

- Stimulant medications, which can be taken on a daily basis, but should only be taken when their benefits outweigh the risks. Regular breaks (or medication holidays) in taking these medications is encouraged

All of these medications, because of their legal classification, have the following additional rules. Failing to follow these rules will result (in most circumstances) in discontinuing the prescribing of any of these medications to you and/or discharge from this provider.

- Patients should never share medication with family members or friends.
- All patients will be required to sign the Controlled Substance Prescribing Policy and Urine Drug Testing Policy.
- Patients should not get medications in the same class from other providers
- If you are prescribed a controlled substance by another provider (such as pain medication), you must inform this office.
- Patients should not use illegal drugs while taking these medications
- These medications will not be refilled early for any reason (even if medications are lost or stolen). No paper prescriptions will be provided from this office

The goal is to maximize the length and quality of life of the lives of our patients. These rules are in place so that we can accomplish that without putting ourselves or our patients at risk. While we do not wish to withhold treatment that will help patients, patients must understand that these medications cause significant harm to many in our society, and so should only be taken with great caution.

Urine Drug Testing Policy

Applies to all patients (including children) taking controlled drugs, including stimulants and benzodiazepines.

Purpose of Urine Drug Testing:

- To determine whether medications are being taken as prescribed
- To determine whether illicit substances or other controlled substances are being taken.
- To comply with state and federal requirements for the prescription of these medications, and to ensure that patients are using the medication safely and responsibly

All patients taking controlled drugs will be tested randomly prior to seeing the provider. Patients with unexplained abnormal tests are (at our discretion) subject to:

- Dismissal from the practice
- No longer being prescribed controlled drugs.

Important Advice

- Be honest. If you have not taken your medication, or if you have used an illegal drug, TELL US.
- Understand that we will do our best to be reasonable with this policy.
- Your test results are private and confidential. These results will never be released to your employer or school. Drug testing is done for your safety.

Responsible Party Name (printed)

Date

Responsible Party Signature

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.

The Jackson Center and its providers must by law keep your health information private and give you notice of its legal duties and privacy practices for your health information.

I. How The Jackson Center May Use or Disclose your Health Information

In certain situations, which will be described in Section II below, we must obtain your written authorization in order to use and/or disclose your protected health information (PHI). However, we do not need any type of authorization from you for the following uses and disclosures of your PHI (including, if any, your HIV/AIDS related, genetic information, sexually transmitted disease or tuberculosis information):

1. Treatment. We use and disclose PHI to physicians, nurses and other health care personnel who provide you with health care services or are involved in your care. In addition, we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

We may also disclose PHI to other providers involved in your treatment.

2. Payment. We may use and disclose PHI to obtain payment for services that we provide to you. For example, disclosures to claim and obtain payment from your health insurer, HMO or other company that arranges or pays the cost of some or all of your healthcare to verify that your payer will pay for health care. You should be aware if you are not the policy holder, certain information may be disclosed to the policy holder by the insurance carrier.
3. Healthcare operations. We may use and disclose PHI for our healthcare operations, which include internal administration and planning and various activities that improve the quality and cost effectiveness of care that we deliver to you. For example, we may use PHI to evaluate the quality and competence of our physicians, licensed psychologists, licensed professional counselors, and other provider types. We may disclose PHI to our administrative staff to conduct medical reviews, needs assessment, and to check quality control of services available. We may also provide PHI to your other healthcare providers when such PHI is required for them to treat you, receive payment for services they render to you, or conduct certain health care operations, such as quality assessment and improvement activities, reviewing the quality and competence of healthcare professionals, or healthcare fraud and abuse detection or compliance.
4. Information provided to you. The Jackson Center allows you to look at your medical records. You must make the request in writing. If we do not have your PHI but we know who does, we will tell you how to get it.
5. Notification and communication with family. We may disclose PHI to a family member, your personal representative or any other person identified by you responsible for your care about where you are, your general condition, or if you die. If you are able and can agree or object, The Jackson Center will give you a chance to object prior to making this notification. If you are unable or cannot agree or object, our health professionals will use their best judgment in telling your family and others.
6. Required by law. As required by law, we may use and disclose you PHI.
7. Public health. We may disclose your PHI to public health authorities for purposes related to: preventing or controlling disease, report child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
8. Health oversight activities. We may disclose your PHI to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and administrative proceedings. We may disclose your PHI in the course of any administrative or judicial proceeding.
10. Specialized government functions. We may disclose your PHI for the military, national security, correctional institutions and government benefits purposes.
11. Law enforcement. We may disclose your PHI to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.
12. Deceased person. We may disclose your PHI to coroners, medical examiners and funeral directors.
13. Research. We may disclose your PHI to those doing research that we have approved.
14. Public Safety. We may disclose your PHI to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. Worker's compensation. We may disclose PHI to comply with worker's compensation laws.
16. Provider's Incapacity or Death. We would disclose PHI to a designated provider in the event of incapacitation or death of your provider. The other licensed professional will then be able to supply patients with copies upon receiving and an appropriate signed medical records release, or transfer records to a provider chosen by the patient or guardian.

II. When The Jackson Center May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices; The Jackson Center will not use or disclose your health information without your written authorization. If you do authorize The Jackson Center to use or disclose your PHI for another purpose, you may take back your authorization in writing at any time.

III. Your Health Information Rights

1. You have the right to ask for restrictions on certain uses and disclosures of your PHI. The Jackson Center does not have to agree to the restriction that you request.
2. You have the right to get your PHI through a reasonable alternative means or at an alternative location. You must present a written The Jackson Center form which tells your specific request. There will be a charge to get this information. (\$1.00 per page for a maximum of \$25.00-Per Request). A valid signed consent form has to be on file before records are released to anyone other than the patient (or parent/guardian).
3. You have the right to see and obtain a copy of your PHI. Under limited circumstances, we may deny you access to a portion of your records. (You should take note that, if you are a parent or legal guardian of a minor, certain portions of the minor's medical record will not be accessible to you including records relating to pregnancy, abortion, sexually transmitted disease, substance use and abuse, and contraception and/or family planning services.) You must submit a completed The Jackson Center Release of Information form. If you request copies, \$1.00 per page for a maximum of \$25.00-Per Request.
4. You have the right to request that The Jackson Center change your PHI that is not correct or complete. The Jackson Center does not have to change your PHI if we feel that the information is correct or other special circumstances apply.
5. You have a right to get a list of disclosures of your PHI made by The Jackson Center, except for disclosures for: treatment, payments, healthcare operations, information provided to you, certain government functions of Section I of this

Notice of Privacy Practices during any period of time prior to the date of your request, provided such period does not exceed six years.

IV. Changes to this Notice of Privacy Practices

The Jackson Center reserves the right to change this Notice at any time in the future, and to make the new provisions effective for all information that it keeps, including information that was created or received prior to the date of such change. Until such change is made, The Jackson Center must comply with this notice. If we change this Notice, we will post the new notice in waiting areas and have copies available upon your request.

If you have questions about any part of this notice or if you want more information about the privacy practices at The Jackson Center, please contact:

Ben Harrell, Business Manager
6880 Cobblestone Blvd., Suite 2
Southaven, MS 38672

Acknowledgment of Forms and Information

I acknowledge I was offered and reviewed:

- 1) A copy of the Notice of Privacy Practices,
- 2) The office Policies and Procedures, including consent to treatment, and 3) The financial agreement for The Jackson Center

I also had the opportunity to ask questions about any of the above documents and had them sufficiently answered.

Responsible Party Name (printed)

Date

Responsible Party Signature