QUALITY BEHAVIORAL HEALTH, INC.

PATIENT INTERVIEW SHEET

May I (or my billing service) contact you at work? Yes No Coccupation:		DATE:
Address: City: State: ZIP: Home Phone: Work Phone: Cell: Sex: Male Female Age: Marital Status: S M D W OTHER Pharmacy Phone Number: May I (or my billing service) contact you at work? Yes No_ Occupation: Employed by: Referred By: Primary Physician: Address: Phone #: FAMILY INFORMATION Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Type: PPO POS HMO Policy Number: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoric Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federal and I have been presented before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records and personal information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the surface of the party that and the pa	Patient Name:	Date of Birth: SSN:
May I (or my billing service) contact you at work? Yes No Coccupation:	Address:	5
May I (or my billing service) contact you at work? Yes No Coccupation:	City:	State: ZIP:
May I (or my billing service) contact you at work? Yes No Coccupation:	Home Phone: Wor	k Phone: Cell:
May I (or my billing service) contact you at work? Yes No Coccupation:	Sex: Male Female Age:	Marital Status: S M D W OTHER
Cocupation:	Pharmacy Phone Number:	
Referred By: Primary Physician: Address: Phone #: FAMILY INFORMATION Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information in vith respect and strict confidentially, however we reserve the right to disclose limited amounts of complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing company stating that your confidential med	May I (or my billing service) contact you at wo	rk? Yes No
Referred By: Primary Physician: Address: Phone #: FAMILY INFORMATION Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information in vith respect and strict confidentially, however we reserve the right to disclose limited amounts of complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing company stating that your confidential med	Occupation:	Employed by:
Address: Phone #: FAMILY INFORMATION Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing company stating that your confidential medical	Referred By:	
FAMILY INFORMATION Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Mother's Name: Type: PPO POS HMO Policy Number: Group Number: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Group Number: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information with respect and strict confidentially, however we reserve the right to disclose limited amounts of onformation to our third party medical billing company. In any other circumstance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the position of the party medical billing company is tating that your confidential medical records will be used for yo	Primary Physician:	
Person to notify in case of an emergency: Phone: If the patient is under 18 years of age: Father's Name: Mother's Name: Mother's Name: INSURANCE INFORMATION Primary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: Secondary Insurance coverage: Type: PPO POS HMO Policy Number: Group Number: Policy Holder's Name: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company. Is any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your	Address:	Phone #:
Insurance coverage:	FAMII	LY INFORMATION
INSURANCE INFORMATION Primary Insurance coverage:	Person to notify in case of an emergency:	Phone:
INSURANCE INFORMATION Primary Insurance coverage:	If the nationt is under 18 years of age:	
Primary Insurance coverage:		Mother's Name:
Policy Number:		
Policy Number:		
Policy Holder's Name:	Primary Insurance coverage:	
Insured's date of birth: Phone # on back of card: Type: PPO POS HMO Policy Number: Group Number: Relationship: Relationship: Insured's date of birth: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authorize Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the	Policy Number:	Group Number:
Secondary Insurance coverage:	Policy Holder's Name:	Relationship:
Policy Number:	Insured's date of birth:	Phone # on back of card:
Policy Number:	Secondary Insurance coverage:	Type: PPO POS HMO
Policy Holder's Name: Insured's date of birth: Phone # on back of card: Phone # on back of card: All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authoriz Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federa law. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the	Policy Number:	Group Number:
All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authorize Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federalaw. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the	Policy Holder's Name:	Relationship:
All patient insurance obligations (such as deductibles and co payments) are due on the date of your appointment. I hereby request payment of medical benefit either to myself or to the party that accepts assignment. I hereby authorize Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federalaw. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the	Insured's date of birth:	Phone # on back of card:
Quality Behavioral Health to release any information in the course of my examination and treatment to be used for the sole purposes of insurance collections and other medically necessary circumstances or as mandated by State or Federalaw. I also understand that I may be charged the full cost for my office visit should I not provide sufficient notice before cancellation as dictated by office policy. This office will treat all of your medical records and personal information with respect and strict confidentially, however we reserve the right to disclose limited amounts of information to our third party medical billing company. In any other circumstance allowed by law and necessary to complete your treatment, we will obtain prior authorization from you before releasing any medical or other billing related information. Your services may be billed electronically to your insurance company using the highest level of data security. This office has a contract with our insurance billing company stating that your confidential medical records will be used for your treatment and insurance billing only. You have the right to view any information that the	· ·	
office has received regarding your medical history and billing records given reasonable advance notice. Please inform us if you have nay concerns regarding your privacy, billing records or any other information. SIGNATURE: DATE:	Quality Behavioral Health to release any informatio sole purposes of insurance collections and other med law. I also understand that I may be charged the ful before cancellation as dictated by office policy. This information with respect and strict confidentially, he information to our third party medical billing compactomplete your treatment, we will obtain prior author related information. Your services may be billed eled data security. This office has a contract with our instruction records will be used for your treatment and insurance office has received regarding your medical history a us if you have nay concerns regarding your privacy,	n in the course of my examination and treatment to be used for the dically necessary circumstances or as mandated by State or Federal l cost for my office visit should I not provide sufficient notice is office will treat all of your medical records and personal owever we reserve the right to disclose limited amounts of any. In any other circumstance allowed by law and necessary to rization from you before releasing any medical or other billing extronically to your insurance company using the highest level of surance billing company stating that your confidential medical see billing only. You have the right to view any information that this and billing records given reasonable advance notice. Please inform billing records or any other information.

STATEMENT OF PATIENTS' RIGHTS

AS A PATIENT YOU HAVE THE RIGHT:

- ▲ To be informed in the language that you understand
- ▲ To be informed about what to expect during the treatment process.
- ▲ To be informed of the cost of services rendered to you and to your family as soon as the information is available.
- ▲ To know the benefits, risks, and side effects of all medications and treatment procedures that may be prescribed for you and to be apprised of alternate procedures.
- ▲ To refuse treatment or any procedures or specific medication that are unusual, hazardous, and/or experimental.
- ▲ To have competent, qualified, experienced clinical staff to supervise and carry out your
- ▲ To be referred to an alternate treatment setting if you are inappropriate or ineligible for treatment at the present level of care.
- ▲ To expect confidentiality and your privacy respected from the entire staff with respect to your identity, diagnosis, prognosis, and treatment
- ▲ To be encouraged and assisted throughout your treatment to understand and exercise your rights as a client without fear of restraint, interference, discrimination, or reprisal.

YOU HAVE TO RIGHT TO KNOW:

- ▲ The name and specialty of any of the professionals responsible for your care.
- ▲ Any rules and regulations of the facility which apply to your behavior as a patient.
- ▲ No client shall be requested to perform services for the facility which are not stated as part of your program treatment plan
- ▲ No client shall be allowed to perform services in lieu of treatment fees.
- ▲ There shall be evidence that the facility has a mechanism for allowing the client and/or legal guardian to present suggestions or grievances.

YOU HAVE THE RIGHT:

To file a complaint with:

Executive Director Quality Behavioral Health, Inc. 75 Lambert Lind Highway Warwick, RI 02886

In accordance with Title VI of the Civil Rights Act of 1964 (42 USC S2000d et. esq.); 45 CFR Part 80. Section 504 of the Rehabilitation Act of 1973, as amended: (28 USC \$794): 45 CFR Part 84 t

Age Discrimination Act of 1975, as amended, 45 CFR Part discriminate on the basis of race, religion, sex, sexual orien or age in admission or access to treatment or employment in	91, Quality Behavioral Health does no tation, color, national origin, handicap,
I have read and understand all of my rights as a patient.	
SIGNATURE	DATE