QUALITY BEHAVIORAL HEALTH, INC.

PATIENT INTERVIEW SHEET

DATE: _____

Patient Name: _____ Date of Birth:_____ SSN:_____
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: _____ 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 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 Federal 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 this 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: _____

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 treatment
- ▲ 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 S794); 45 CFR Part 84, Age Discrimination Act of 1975, as amended, 45 CFR Part 91, Quality Behavioral Health does not discriminate on the basis of race, religion, sex, sexual orientation, color, national origin, handicap, or age in admission or access to treatment or employment in its programs or activities.

I have read and understand all of my rights as a patient.

_____ _____

SIGNATURE DATE