Please download, fill out, and email form
to office@imaginebh.com
A typed signature is adequate.

Client Registration

ALL information is required – If you have insurance you must complete ALL insurance questions.

Client Name: _____ Age: _____ Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

Address: _____
Street *Apt. #* *City,* *State* *Zip Code*

SSN#:_____-_____-_____Current living situation: ☐ alone *OR* ☐ with my _____

Circle YES or NO next to each number listed, to indicate if it is OK to leave a message May we send Appointment Texts? *YES* ☐ *NO* ☐

Home (_____)____ - _____ *YES*☐*NO*☐ Cell (_____)_____-_____ *YES*☐*NO*☐ Email: _____ *YES*☐*NO*☐

Marital Status: ☐ Single ☐ Married/Partner ☐ Divorced ☐ Separated ☐ Widowed ☐ Minor

Occupation: _____ Employer: _____ Employment Status: _____

Please list all persons you wish to involve in your treatment: _____

_____

INSURANCE INFORMATION - REQUIRED ☐Insurance ☐EAP ☐Self Pay

Primary Insurance Co: REQUIRED _____

Name of Insured Person (parent/employee): _____ Insured's SSN: __ __ __ - __ __ - __ __ __ __

Member ID#: REQUIRED _____ Group #: NA _____

Relationship to Client: _____ Insured's Date of Birth: _____/_____/_____

**If your Mental Health/Substance Abuse benefits are subcontracted to a different insurance provider, i.e. Magellan, Beacon Health, Value Options, American Behavioral, it is your responsibility to inform the front office. This will allow us to charge you correctly for services rendered.*

REFERRAL INFORMATION:

☐Individual Counseling ☐IOP ☐Medication Management

Person/agency who referred you: _____ Reason for referral: ☐Court Ordered ☐Bariatric Evaluation ☐EAP

EMERGENCY CONTACT: **A consent is required for your Emergency Contact. Please fill out the appropriate consent form.**

Name: _____ Relationship: _____ Phone: (____) ____-_____

AGREEMENT:

I certify that the information on this document is true & correct (Please sign and date below):

Signature: _____ **Date:** _____

Client/Guarantor

All information is used strictly for the purposes of Imagine, LLC. Medical information provided is protected by federal HIPAA regulations.

MEDICAL INFORMATION

Primary Care Physician: _____
Name

Date of and Reason for Last Visit: _____

Psychiatrist: _____ _____
Name *Group or Agency if Applicable*

Date of and Reason for Last Visit: _____

Do you have any medical conditions (Including Hospitalizations): _____
_____
_____

List all current medications: (Name, Frequency, Dosage): _____
_____
_____

Known allergies/medication reactions: _____
_____
_____

In case of emergency what is your hospital preference:_____

Medical History

Yes	No	*If YES*, please explain:
☐	☐	Medical Emergencies (Seizures, Stop Breathing, Blackouts, Traumatic Brain Injury)
☐	☐	Diabetes ☐I ☐ II
☐	☐	Weight Change (If YES, please list amount of weight loss/gain):
☐	☐	Blood Pressure
☐	☐	Short Term/Long Term Memory
☐	☐	Appetite Disturbance
☐	☐	Sleep Disturbance

Additional Information

☐	☐	Currently experiencing thoughts of harming others?
☐	☐	Currently experiencing thoughts of suicide?
☐	☐	Ever attempted suicide in the past?
☐	☐	Have drugs or alcohol been disruptive to your life?
☐	☐	Are you currently being abused?
☐	☐	Is anyone requiring you to be here? - Please provide person or agency

Chief Concern

Briefly, why are you here? _____
_____
_____
_____
_____
_____
_____

NOTICE OF PRIVACY AND CONFIDENTIALITY

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.

General Information:

The confidentiality of alcohol and drug abuse client records maintained by Imagine is protected by two federal laws: the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. § 132d et seq., 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd-2, 42 C.F.R. Part 2. Generally, Imagine may not say to a person outside the program that you attend the program, nor disclose any information identifying you as an alcohol and/or drug user, or disclose any other protected information except as permitted by federal law. Imagine must obtain your written consent before it can disclose information about you for payment purposes. For example, Imagine must obtain your written consent before it can disclose information to your health insurer in order to be paid for services. Generally, you must also sign a written consent before Imagine can share information for treatment purposes or for health care operations. However, federal law permits Imagine to disclose information *without* your written permission:

1. Pursuant to an agreement with a qualified service organization/ business associate;
2. For research, audit or evaluation;
3. To report a crime committed on Imagine premises or against Imagine personnel;
4. To medical personnel in a medical emergency;
5. In connection with treatment, payment (insurance company) or health care operations;
6. To appropriate authorities to report suspected child or elder abuse and/or neglect;
7. As allowed by a court order.

Before Imagine can use or disclose any information about your health in a manner which is not described above, we must first obtain your specific written consent allowing it to make the disclosure. Any such written consent may be revoked by you in writing.

Your Bill of Rights

Under HIPAA you have the right to request restrictions on certain uses and disclosures of your health information. Imagine is not required to agree to any restrictions you request, but if it does agree then it is bound by that agreement and may not use or disclose any information which you have restricted except as necessary in a medical emergency. You have the right to request that we communicate with you by alternative means or at an alternative location. Imagine will accommodate such requests that are reasonable and will not request an explanation from you. Under HIPAA you also have the right to inspect and copy your own health information maintained by Imagine, except to the extent that the information contains psychotherapy notes or information compiled for use in a civil, criminal or administrative proceeding or in other limited circumstances. Under HIPAA you also have the right, with some exceptions, to amend health care information in Imagine records, and to request and receive an accounting of disclosures of your health related information made by Imagine during the six years prior to your request. You also have the right to receive a paper copy of this notice.

A. In accordance with Title 6 of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, Title 9, Section 10800, and Americans with Disabilities Act of 1990, each person receiving services from an alcoholism or drug abuse recovery or treatment facility shall have rights which include, but are not limited to, the following:

1. The right to confidentiality as provided for in Title 42, Code of Federal Regulations, Part 2 and HIPAA and the right to receive this Privacy Notice.
2. To be accorded dignity in contact with staff, volunteers, board members and other persons. You have the right to have your rights explained to you in simple terms, in a way you can understand within 24 hours of admission, which can help in decision-making.
3. To be accorded safe, healthful and comfortable accommodations to meet his or her needs. You have the right to a humane environment that provides reasonable protection from harm and appropriate privacy for your personal needs.
4. To be free from verbal, emotional, physical abuse, inappropriate sexual behavior or contact, exploitation, humiliation, harassment and/or neglect.
5. To be informed by the program of the procedures to file a grievance (without fear of retaliation) or appeal discharge.
6. To be free from discrimination based on ethnic group identification, culture, sexual orientation, religion or spiritual beliefs, age, gender, skin color, socioeconomic status, language, or disability.
7. To be accorded access to his or her file and the right to own the information within his or her file with the exception of psychotherapy notes.
8. The right to request corrections of erroneous and/or incomplete information.
9. The right to prohibit re-disclosure of client information.
10. The right to request transmittal of communications in an alternative manner.
11. The right to obtain an accounting of disclosures.
12. The right to express preferences regarding counselor or service providers.

13. Fiduciary abuse of the participants is prohibited.
14. To be free from any marketing or advertising publicity without written authorization.
15. The right to provision of services will be responsive to the participants' social support and legal advocacy needs, when necessary.
16. The right to be free from intrusive procedures (strip searches or pat downs).
17. If you agree to treatment or medication, you have the right to change your mind at any time (unless specifically restricted by law). You have the right not to receive unnecessary or excessive medication.
18. You have the right to accept or refuse treatment after receiving this explanation.
19. You have the right to appropriate treatment in the least restrictive setting available that meets your needs.
20. You have the right to be told about the program's rules and regulations before you are admitted. You also have the right to be told what is to be expected of treatment.
21. You have the right to be told before admission:
    a. the condition to be treated;
    b. the proposed treatment;
    c. the risks, benefits, and side effects of all proposed treatment and medication;
    d. the probable health and mental health consequences of refusing treatment;
    e. other treatments that are available and which ones, if any, might be appropriate for you; and
    f. the expected length of stay.
22. You have the right to a treatment plan designed to meet your needs, and you have the right to take part in developing that plan. You also have the right to meet with staff to review and update the plan on a regular basis.
23. You have the right to be told in advance of all estimated charges and any limitations on the length of services of which Imagine is aware.
24. You have the right to receive an explanation of your treatment or your rights if you have questions while you are in treatment.

B. Each participant shall review, sign and be provided at admission, a copy of the participant rights specified in A1 through A24 above. The program shall place the original signed bill of rights document in the participant's file.
C. The provider shall post a copy of the participant rights in a location visible to all participants and the general public.
D. The follow-up after discharge cannot occur without a written consent from the participant.
E. Any program conducting research using participants as subjects shall comply with all federal regulations for protection of human subjects (Title 45. Code of Federal Regulations 46.) However, you have the right to refuse to take part in research without affecting your regular care.

Imagine Duties
Imagine is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. Imagine is required by law to abide by the terms of this notice. Imagine reserves the right to change the terms of this notice and to make new notice provisions effective for all protected health information it maintains. Revised notices will be posted in all Imagine offices and website, as well as given to all active patients.

Complaints and Reporting Violations
You may complain to the Secretary of the United States Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 20201, to MS State Board for Examiners for Licensed Professional Counselors PO Box 1497, Yazoo City, MS 39194 and to the MS Department of Mental Health at 1101 Robert E. Lee Building, 239 N Lamar St., Jackson, MS 39201 if you believe that your privacy rights have been violated under HIPAA. Imagine will take no retaliatory action against you if you file a complaint about our privacy practices.

Contact:
If you have questions about this notice or any complaints, please contact our President at 601-982-5376.
Violation of the Confidentiality Law by a program is a crime. Suspected violations of the Confidentiality Law may be reported to the United State Attorney in the district where the violation occurs.

Effective Date: This notice comes into effect on July 1, 2008.

Acknowledgement: I hereby acknowledge that I received a copy of this notice.

Client Signature: _____ Date: _____

Imagine was unable to obtain this acknowledgement of receipt due to:
☐Client refused to sign acknowledgement ☐Client was unable to sign acknowledgement ☐Client left the facility before the end of the assessment and is not entering treatment ☐Other:_____

Consent for Treatment Agreement

I have chosen to receive mental health and/or substance abuse services for myself and/or my child from Imagine Behavioral Health. My decision is voluntary and I understand that I may terminate these services at any time, unless my participation has been mandated by a court of law.

Nature of Mental Health Services

I understand that during the course of treatment I may need to discuss material of any upsetting nature in order to resolve my problems. I also understand it cannot be guaranteed that I will feel better after completion of treatment.

Compliance with treatment plan

I agree to participate in the development of an individualized treatment plan. I understand that consistent attendance is essential to the success of my treatment. Frequent "no shows" and/or late cancellations may be grounds for termination of services, as well as failure to follow my treatment plan in any form.

Supervision

I understand there are certain circumstances which may require Imagine Behavioral Health provider(s) to receive supervision. These circumstances include, but are not limited to the following:

- State licensure regulations may require my therapist or service provider to receive ongoing supervision
- Accreditation organizations, as well as insurance companies, may require that my treatment plan be reviewed
- The standards of care which guide most mental health professional recommend that supervision and/or consultation be obtained in high risk situations such as threats and/or acts of harm to self or others
- Other special circumstances, such as preparation to testify in court

Client Rights

The right to be treated with dignity and respect by all staff
The right to be involved in the planning and/or revision of my treatment plan
The right to know about my treatment progress or lack thereof
The right to reject the use of any therapeutic technique, and to ask questions at any time about the methods used
The right to be spoken to in a language that is fully understood
The right to a clean and safe environment
The right to refuse to be video-taped, audio recorded, or photographed
The right to end treatment at any time unless court ordered
The right to file a complaint or grievance about the agency or staff
The right to confidentiality of clinical records and personal information according to federal and state laws

Emergencies

I understand I may reach my Imagine Behavioral Health provider at (601) 982-5376. If not available, I can leave a message and my call will be returned as soon as possible. If I have a life-threatening emergency situation, I may call 911.

I have read, discussed and understood all of the above.

_____ _____

Patient Signature Date

Imagine Behavioral Health: CONTROLLED SUBSTANCE AGREEMENT

The purpose of this agreement is to protect your access to controlled substances and to protect our ability to prescribe for you. The long-term use of controlled substances is controversial because of uncertainty regarding the extent to which they provide long-term benefit. Additionally, there is also the risk of addictive disorder developing or relapse of prior addiction, and the extent of this risk is not certain. Because these drugs have potential for abuse and/or diversion, strict accountability is necessary when use is prolonged. For this reason, the following policies are agreed by you, the patient, as consideration for, and a condition of, the willingness of the provider whose signature appears below to consider the initial and/or continued prescribing of controlled substances to treat your condition.

PLEASE INITIAL NEXT TO EACH POLICY

_____The cost for the onsite urine screen is $25 at the time of service. If lab services are needed for verification there will be an additional $40 fee. Insurance will not apply to these fees.

_____All controlled substances for treatment of my condition must come from the provider whose signature appears below or, during their absence, by the designated covering provider.

_____All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies; I will inform the office as soon as possible. The pharmacy that I have selected is listed below.

_____I will not share, sell, or otherwise permit others to have access to these medications. I will not take other people's medications (including family members). Both of these activities are illegal and can result in prosecution.

_____I will only take medications that I am prescribed. I will not take my medications at a greater dose or frequency that what is prescribed. I will not take old "leftover" medications to supplement my current treatment.

_____I will inform the office of all medications, conditions, and adverse reactions that I may have. The prescribing provider below has my permission to discuss all treatment details with dispensing pharmacies and any other professionals who provide my healthcare for purposes of coordinating care and maintaining accountability.

_____Urine drug screens will be performed depending on the controlled substances prescribed, to comply with regulations set forth by the MS State Board of Medical Licensure and our practice. The presence of unauthorized or illegal substances or the absence of the prescribed medication may result in discontinuation of the prescription and/or a referral for a substance abuse evaluation.

_____Refills are contingent on keeping scheduled appointments. If I cancel of no show for my appointment, my prescription will not be refilled until I am seen in clinic. Refills for controlled substances will not be called in.

_____I understand that according to the MS State Board of Medical Licensure, my provider must regularly check the MS Prescription Monitoring Program database prior to prescribing my medication. Depending on the controlled substance prescribed, this must be done every 3 months, and I must attend scheduled appointments the meet these requirements.

_____I understand that my medications will not be replaced if they are lost, stolen, get wet, or are left somewhere by mistake. No exceptions will be made and early refills will not be given.

_____I understand that my medications should not be stopped abruptly, as an abstinence syndrome (drug withdrawal) could develop.

_____I understand that my medication may be hazardous or lethal to a person who is not tolerant to their effects, especially a child, and I agree to keep them out of the reach of such people.

_____I also understand that my medications may impair my ability to drive a vehicle or operate machinery; therefore, I will not drive or operate machinery while taking these medications. I will notify my employer or DOT if my employment involves these activities and will engage in these activities at my own risk.

_____I understand that if the responsible legal authorities have questions concerning my treatment, as might occur, for example, if I were obtaining controlled substances at several pharmacies or from several different sources, all confidentiality is waived and these authorities will be given full access to my records of prescribing controlled substances.

I acknowledge that the risks and potential benefits of chronic long term treatment with controlled substances have been explained and fully accept all risks associated with their use. My signature below affirms that I have read, understand, and accept all of the above terms and agree to be bound by this agreement. I also understand that this contract will automatically renew annually unless changes occur causing the need for revision.

Patient Name:_____ Date:_____

Patient Signature:_____ Physician/NP Signature:_____

All information is used strictly for the purposes of Imagine, LLC. Medical information provided is protected by federal HIPAA regulations.

Imagine Behavioral Health
Credit Card Authorization Form

Policy: We require all patients to have a credit/debit card on file in order to pay copays and coinsurance. The amounts charged will be agreed upon ahead of time. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other_____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize *Imagine Behavioral Health* to charge my credit card above for agreed upon Copays/Coinsurance. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

**If you would prefer to provide this information over the phone please call the office.*

No Show/Cancellation Policy

Policy: Failure to notify the office **24 hours in advance** of your scheduled appointment that you are unable to attend will result in a charge in the amount of $50 for Medical and $100.00 for Therapy. ***Your credit card on file will be charged this fee and/or this fee must be paid before making another appointment.***

Please note: **THIS CHARGE IS NOT COVERED BY YOUR INSURANCE.**

Your signature below is your acknowledgement of the No Show/Cancellation Policy.

_____ _____

Patient Signature Date

Family and Caregiver Release of Information

Oftentimes mental health and substance abuse treatment involves family members and caregivers. They can be valuable sources of information and support. It is our goal to provide you with the best care possible. However, it is also our legal obligation to honor your right to privacy.

Please list below the individuals you would like to be involved in your treatment. If they are not listed below we cannot discuss any aspect of your care here at Imagine, apart from imminent danger to self or others.

I authorize Imagine Behavioral Health, to disclose to and/or obtain information regarding my care here at Imagine with the following people:

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____
_____	_____

- The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:
  _____
  _____

- I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Imagine, LLC, at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

- Unless sooner revoked, this authorization expires on 6 months from the date of this disclosure, or as otherwise indicated:
  _____

- I further understand that Imagine, LLC (DBA) Imagine Behavioral Health will not condition my treatment on whether I give authorization for the requested disclosure.

- Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse and/or mental health treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. Other types of information may be re-disclosed by the recipient of the information in the following circumstances:

_____ _____

Signature of Client **Date**

_____ _____

Signature of Parent, Guardian or Personal Representative **Date**

If you are signing as a personal representative of an individual, please describe your authority to act for this individual:

_____

_____

All information is used strictly for the purposes of Imagine, LLC. Medical information provided is protected by federal HIPAA regulations.