CBA HEALTHCARE LLC
1155 W 4th Street Suite #101 Reno, Nevada 89503
775-200-8528/ Fax 775-800-1551

PATIENT INTAKE FORM

Date_____

GENERAL INFORMATION

REFERRAL SOURCE: _____

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Address

City | State | Zip Code

Main Phone | Other Phone

Emergency Contact | Relationship | Phone :

Do you want CALL/TEXT/or EMAIL REMINDERS (Cir One)? Email _____

Parent/Guarantor Information

First Name | Last Name | Gender

Date of Birth (mm/dd/yyyy) | Social Security Number

Name of person completing this form

Relationship to patient

Parent Marital Status: ☐ Married ☐ Divorced ☐ Widowed

Who has legal/physical custody? _____

Please provide legal documentation if necessary, for the information above (custody).

INSURANCE INFORMATION

Is there secondary insurances? Y Or N

PRIMARY INSURANCE | Policy Holder

Policy Holder D.O.B. (mm/dd/yyyy) | Relationship

Policy Holder Address

City | State | Zip Code

Policy Number | Group Number

Additional Insurance: _____ Policy # _____ Grp#_____

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CONSENT TO TREATMENT

First Name _____ Last Name _____

You are about to take a very important step in your mental wellness plan, and you are seeing a mental health professional. As your mental health provider, we will be entering a protected relationship. Treatment might involve a multidimensional family approach. Due to this consent is needed for all those attending sessions.

We are treating you and we will do our best to accurately diagnose you and design a comprehensive treatment plan that will enable you to continue with a normal emotional development. This may include recommendations of therapy, or medications. This is all part of the service of a mental health professional. I give consent to bill my insurance for services provided.

_____ (Initial)

You are our client and have confidentially rights. Confidentiality does not apply under certain situation: We are obligated by law to report any suspicion of child abuse. This includes physical or sexual abuse. Also, we have a duty to protect if we suspect anyone is in danger of killing themselves or has made threats to hurt someone else.

_____ (Initial)

If I require or think it is in your best interest to communicate with an outside source, I will request a release of information. To assure good therapeutic care, frequent appointments are required. Unless arranged otherwise, clients that have not been seen in 3 months will be considered inactive.

_____ (Initial)

I, _____(client), do hereby seek and consent to take part in the treatment provided by CBA HEALTHCARE, LLC. If I am attending group services I also understand and consent that confidentiality still applies and that CBA HEALTHCARE, LLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with this provider and regularly reviewing our work toward the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this mental health professional.

_____ (Initial)

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CONSENT TO TREATMENT

I, _____(Client), understand that CBA HEALTHCARE LLC. works in connection with the Collection Service of Nevada. If for any reason my account is not paid in full after three months of the date I was billed I understand that my contact information and statement may be released to the Collection Service of Nevada.

_____ (Initial)

CBA HEALTHCARE LLC: NONE of our clinicians participate in custody proceedings

_____ (Initial)

I am aware that if I attempt to contact my provider through phone, email, text, or any other form of communication over the Internet, my information may not be completely secure. In the event that my information is intercepted, CBA HEALTHCARE is not responsible for the breach of patient privacy. Below are the approved contact means to leave messages on or respond to if contacted:

Phone _____ Email _____

_____ (Initial)

Client Name (please print) _____

Client Signature _____ Date _____

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HIPAA NOTICE/PRIVACY PRACTICES

First Name _____ Last Name _____

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.

CBA Healthcare, LLC

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

See front office for "HIPPA Detail" forms.

Client Name (please print) _____

Client/Guardian Signature _____ Date _____

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APPOINTMENT CANCELLATION AGREEMENT

First Name _____ Last Name _____

We understand things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, the office of CBA HEALTHCARE requires 24 business hours' notification (Monday through Friday 8:00 am to 5:00 pm). Please understand that we set aside this time for you. This policy is in place to give the office enough time to schedule another client in that time slot, if you are unable to attend. If you fail to cancel within the 24 hours prior to your appointment a $75 fee will be charged to the card below or the credit card on file. If you are a Medicaid patient you are not subject to the $75 fee, however, after 2 violations of this agreement, services at this office will be on cancellation openings only.

While we do call to remind you of your appointment, it is your responsibility to call the office at 775-200-8528,

I authorize the following card into the system to be used for co-pays and fees for services provided to:

_____ (Please print patient name).

This includes any and all fees incurred during the time services were provided at the office of CBA HEALTHCARE LLC.

Card Number _____

Expires _____ CVV _____

Printed Name _____

Signature _____ Date _____

I understand that the office of CBA HEALTHCARE LLC will attempt to bill my insurance, however if my insurance does not pay, for whatever reason, I am responsible for any remaining balance. This may include deductibles, copays, or out of pocket expenses.

My signature acknowledges:

- In the case of a Psychiatric Emergency I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above.
- I authorize CBA HEALTHCARE to charge all fees to the card kept on file if not paid within a timely manner (30 days after billed).
- If I have any problems or questions regarding any charges to my account. I will contact Office for assistance. Please call 775-200-8528 or send an email to cbahealthcare@mail.com
- I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with CBA HEALTHCARE LLC.

Client Name (please print) _____

Client/Guardian Signature _____ Date _____

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CBA Healthcare Grievance Policy

Purpose: To address client complaints or expression of dissatisfaction regarding service delivery, or any expression of dissatisfaction by the service provider.

Procedures:

A. The client or service provider will express dissatisfaction either verbally or in writing. This may be done directly with our Clinical Supervisor or Operations Manager. Clients are also able to anonymously submit a grievance or client satisfaction survey and place it in our locked survey box in the front lobby.

B. The Clinical Supervisor and/or Operations Manager shall meet with the client and/or service provider to attempt to resolve the situation.

C. If the situation *is* still not resolved, the Clinical Supervisor shall meet with all parties and try to resolve the situation.

D. If a resolution is not reached, then a transfer of services to another provider will be offered to the client and/or service provider. If this is not possible then termination of services will take place and three referrals will be given to the client.

E. All grievances will be documented in the client's chart.

F. All clients will begiven a copy of the grievance police as part of their intake packet and their signature will be required as part of their consent for treatment.

I have read the Grievance Policy and consent for treatment.

_____ _____

Client Signature Date

_____ _____

Clinician Signature Date

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)

PATIENT AND INSURED INFORMATION

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE MM DD YY SEX M F	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other	7. INSURED'S ADDRESS (No., Street)
CITY / STATE	8. RESERVED FOR NUCC USE	CITY / STATE
ZIP CODE / TELEPHONE (Include Area Code)		ZIP CODE / TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES NO	a. INSURED'S DATE OF BIRTH MM DD YY SEX M F
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? YES NO	c. INSURANCE PLAN NAME OR PROGRAM NAME
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL	15. OTHER DATE QUAL MM DD YY	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. / 17b. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? YES NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO.
		23. PRIOR AUTHORIZATION NUMBER

PHYSICIAN OR SUPPLIER INFORMATION

24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	
								NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back.) YES NO	28. TOTAL CHARGE $	29. AMOUNT PAID $	30. Rsvd. for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE	32. SERVICE FACILITY LOCATION INFORMATION a. b.		33. BILLING PROVIDER INFO & PH # ( ) a. b.		

CARRIER