ARKANSAS FAMILIES FIRST

Child/Adolescent Patient Registration

Patient: _____
(Last) (First) (MI)

Social Security Number: _____ Date of birth _____

Address: _____
(Street) (City) (State) (Zip)

Primary Contact Phone: _____ (Is this a cell phone number? __Yes __No)

Male__ Female__ School Grade: _____ Race: _____ Ethnicity: _____

Would you like to enroll in the Patient Portal to receive:

Email reminders? ___Yes ___No Preferred Email Address: _____

Text message reminders? ___ Yes ___No Preferred Cell #: _____ Carrier: _____

Patient's Primary Care Physician: _____ Phone: _____

Referred By: _____ Phone: _____

Preferred Pharmacy (name/address/phone): _____

Mother's Name: _____ Biological-Step-Adoptive-Guardian (Circle)

Mother's Address: _____

Primary Phone: _____ Work Phone: _____

Social Security Number _____ Date of Birth: _____

Father's Name: _____ Biological-Step-Adoptive-Guardian (Circle)

Father's Address: _____

Primary Phone: _____ Work Phone: _____

Social Security Number: _____ Date of Birth: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Please Provide Insurance Cards and Parent/Guardian Driver's License to our staff

Primary Insurance _____ Phone _____

Address _____

Name of policy holder _____ Date of Birth _____

Identification number _____ Group number _____

Secondary Insurance _____ Phone _____

Address _____

Name of policy holder _____ Date of Birth _____

Identification number _____ Group number _____

ARKANSAS
FAMILIES FIRST

Psychotherapy Agreement

At Arkansas Families First, we strive to provide high-quality mental health services to help improve the life of every patient we encounter. The following will explain our policies and procedures and will serve as a contract between the clinician and the patient.

Therapy Services

Therapy can have benefits and risks. The risks might include experiencing uncomfortable feelings such as guilt, anger, sadness, anxiety, or frustration when discussing aspects of your life. The benefits of therapy include better relationships, solutions to specific problems, increased life satisfaction, improved physical health, and significant reductions in mental health symptoms and feelings of distress.

Therapy sessions are approximately 45-55 minutes in length and are based on the treatment goals that the clinician and the patient agree upon. To get the most out of therapy, your therapist may assign tasks to be completed outside of the session. These opportunities for growth play a large role in successful treatment.

Confidentiality

At Arkansas Families First, your privacy and confidentiality are of utmost importance. Therapy is based on a confidentiality agreement between the clinician and each participant. There are some exceptions to confidentiality that may occur and are as follows:

- If the clinician has a reasonable suspicion of past and/or current physical abuse, sexual abuse, or neglect to a minor, disabled, or elderly adult.
- If the patient has threatened to harm themselves or someone else.
- If a written consent is signed by the patient or guardian to release information or to request specific records.
- If records are subpoenaed by a court of law
- Information is released to insurance companies for billing purposes.
- A 3rd party billing service will have access to certain information as required for insurance authorization and reimbursement. The billing service is bound by the laws and ethics of patient privacy mandated by the Health Insurance Portability and Accountability Act.

When working with children and adolescents, the clinician will maintain confidentiality with the child or adolescent except as noted above. The child or adolescent will, however, be counseled in the value of open communication with his or her parent(s), and parent-child communication will be encouraged and supported.

Billing and Payments

Payment is expected in full at the time of the appointment. Payments can be made by debit card, credit card, check, or cash. If a check does not clear due to insufficient funds or for any other reason, the patient will be billed for any related bank fees incurred as a result of the insufficient funds. Arkansas Families First accepts most insurances.

Emergency Procedures

AR Families First does not provide on-call services. In the event of an emergency, please go to your nearest emergency room or call 911.

4004 McCain Blvd., Suite 203, North Little Rock, AR 72116 Phone: 501-812-4268 Fax: 501-812-4286

Correspondence

Please note that clinicians do not provide therapy sessions by telephone or email. Counseling issues are best handled in a scheduled counseling session. If you have correspondence with your therapist over email, please note that email is not a secure medium for discussing health-related information. We suggest limiting email correspondence to administrative, non-clinical content only. All email correspondence will be inserted into the medical records and saved for future reference.

Friending

In order to preserve the appropriate boundaries of a therapeutic relationship, our therapists do not accept friend or contact requests from current or former clients on any social networking site (Facebook, LinkedIn, etc.)

Arkansas Families First Blog / Website / Podcast and Other Web Content

We maintain a blog on our website to offer information and resources to the families we serve and the public in general. In order to offer this resource to our clients without jeopardizing our confidentiality and privacy agreement, we never post stories about our clients or our experiences in therapy, and we do not correspond through the "comments" sections on the blog page. Any comments left by readers are for other readers, and are not necessarily read by the authors. Our posts are not meant to replace therapy or consultation with a mental health professional.

Following

Some of our clinicians may choose to link our blog articles to their Twitter accounts. If you choose to follow a twitter stream, and use an easily identifiable name, your confidential relationship with your therapist may be compromised.

Cancellations and No Shows

The time that you schedule with a clinician is set aside only for you. If you need to cancel a scheduled appointment, please do so at least 24 hours in advance. If you do not keep your appointment, or if you fail to reschedule or cancel a scheduled appointment with at least a 24-hour notice, you will be charged $50.00 for the appointment.

Professional Records

You have the right to receive a copy of your records (either in print or electronically) if you make a request in writing. Copies of client records are available for an administrative fee that will reflect actual cost of labor, paper copies, usb (for electronic copies), postage or other materials. However, the involved clinician may ask to discuss the request prior to releasing the records. Clinicians can deny record requests if deemed harmful to the client. In such scenarios, you have the right to request a second opinion and another clinician will review the request.

I agree to the policies and procedures in this document. I was given a copy of this agreement and had the opportunity to ask questions or share concerns with the clinician.

_____ _____

Client Signature Date

_____ _____

Parent/Caregiver Signature Date

4004 McCain Blvd., Suite 203, North Little Rock, AR 72116 Phone: 501-812-4268 Fax: 501-812-4286

ARKANSAS FAMILIES FIRST

PATIENT:_____

RESPONSIBLE PERSON:_____

RESPONSIBLE PERSON'S RELATIONSHIP TO PATIENT:_____

Insurance Authorization

I acknowledge that ARKANSAS FAMILIES FIRST, LLC (AFF) and its contracted billing company, Arkansas Therapist Connection, LLC, (ATC) will file insurance claims on my behalf. I authorize assignment of benefits and further give permission for AFF and/or ATC to release information to my insurance company if requested.

Signature_____Date_____

Patient Privacy In compliance with the state and federal requirements of HIPAA I have been provided with a copy or access to AFF's policy and procedures regarding the protection, security, and release of my Protected Health Information.

Signature_____Date_____

Scheduled Appointments

I understand and agree to pay $50 for appointments that I miss if I have not provided AFF with a notice of my intention to cancel within twenty-four (24) hours of the appointment time. I understand that my insurance coverage will not pay and will not be billed for missed appointments.

Signature_____Date_____

Billing and Payment for Services

I agree to pay for services at the time they are provided, unless I have agreed otherwise or unless my insurance coverage requires another arrangement. Further, I understand that AFF and/or ATC staff will contact insurance providers to determine benefits, however, I also understand that neither AFF or ATC can guarantee that the information provided by the insurance provider is accurate. I agree to pay for all agreed to services that **might not be** covered by my insurance plan including non-covered diagnoses or procedures (e.g., testing, group, marital counseling).

Signature_____Date_____

Treatment Coordination

I understand and give consent for AFF treatment providers to share pertinent medical records and information with my primary care physician in order to coordinate care. These may include diagnoses, regular treatment updates, evaluation reports, and other medical/mental health information. My treating physician is _____.

Signature_____Date_____

ARKANSAS FAMILIES FIRST

CONSENT FOR TRANSMISSION OF PERSONAL AND HEALTH INFORMATION BY EMAIL

PATIENT'S INFORMATION:

LAST NAME	FIRST NAME	DATE OF BIRTH

Arkansas Families First, LLC ("Clinic") offers patients the opportunity to communicate by Email for non-urgent matters. This form provides the guidelines regarding Email communications and documents your consent.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

EMAIL USE: Email communications should be between the Clinic and an adult patient 18 years of age or older, or the parent or guardian of a minor.

DO NOT USE EMAIL FOR THE FOLLOWING: Do not use email to communicate sensitive medical information such as diagnosis, personal and family information, treatment records etc. Do not send attachments or forwarded emails. Do not use Email to request records. Please call 501-812-4268.

PRIVACY, SECURITY, AND CONFIDENTIALITY: Although Arkansas Families First, LLC, has implemented reasonable technical safeguards, the Clinic cannot and does not guarantee the privacy, security or confidentiality of any Email messages sent or received over the Internet. There is a potential that Email sent or received over the Internet can be intercepted, altered, forwarded, and/or read by others. The Clinic is not responsible for Email messages that are lost due to technical failure during composition, transmission, or storage. The Clinic will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, you should not communicate with the Clinic through Email.

CREATING A MESSAGE: In the "Subject" line of the email, please include general topic of your message (i.e. appointment, billing question, prescription, etc.). In the body of the message, please include the patient's name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file. Content of the Email should only be used for non-sensitive and non-urgent issues.

EMAIL MESSAGE: Communications are appropriate for administrative tasks only, such as the following types of transactions:

- Appointment scheduling;
- Requests for Resources
- Referrals

RESPONSE TIME: Although Arkansas Families First Clinics will endeavor to read and respond within 24 hours to any Email, we cannot guarantee that any particular Email will be responded to within any particular period of time. If you have not received a response within 3 days, please call your Clinic.

DOCUMENTATION: Email communications regarding treatment will be documented in your Medical Record by placing a copy of the message in your file.

ENDING EMAIL: You may discontinue using Email as a means of communication by sending an Email or letter to the Clinic.

COPY: A copy of this consent form may serve as the original. I know that I have a right to obtain a copy of this consent form if I request one.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email as one form of communication with Arkansas Families First, LLC.

Patient's Signature or Signature of Parent/Legal Guardian if Patient is under 18:	Date:
Print Name:	Relationship to Patient:

ARKANSAS FAMILIES FIRST

CONSENT FOR REQUEST AND RELEASE OF PERSONAL AND HEALTH INFORMATION

PARENT / CAREGIVER INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	RELATIONSHIP TO CHILD

CHILD'S INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

THE FOLLOWING PERSON/AGENCY IS REQUESTED TO RELEASE THE SPECIFIED INFORMATION:	**DESCRIPTION OF INFORMATION TO BE RELEASED:**
Agency Name: Children's Advocacy Alliance Contact: Courtney McPherson, LMSW Address: 574 Locust St City, State, Zip: Conway, AR 72034 Telephone: 501-328-3347 Fax:	X **All Information Relevant to Consultation, Treatment or Diagnosis** **OR** __ Psychological / Educational Evaluation Results __ Psychological Treatment and Diagnostic Records __ Billing and Payment Records __ Medical, Health, or Developmental Information __ Psychological, Behavioral, Educational Information __ Other Information (specify):

THE PERSON OR AGENCY ABOVE IS BEING REQUESTED TO RELEASE MY CHILD'S INFORMATION TO:

Arkansas Families First, LLC
4004 McCain Blvd. Ste 203, North Little Rock, Arkansas 72116
Phone: 501-812-4268; Fax: 501-812-4286

REASON FOR RELEASE OF INFORMATION: __coordination/continuity of care __other (specify): _____

DATE(S) OF SERVICE COVERED BY THIS REQUEST: _____

VOLUNTARY: I know that I am not required to sign this consent form and that my child will not be refused treatment if I do not sign this form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services my child receives from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until _____ (date). If no date is entered, the form will be valid until *the date that I terminate services* with Arkansas Families First, LLC.

WITHDRAWAL OF CONSENT: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written notice to the person or agency asked to release this information. The withdrawal will be valid as soon as the person or agency receives my notice, but will not apply to information that has already been shared after I signed the consent form and before receipt of the withdrawal notice.

SHARING OF INFORMATION: I know that my child's information may be shared more than once by the persons and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. Arkansas Families First, LLC is not responsible for further release of information by other agencies.

COPY: A copy of this consent form may serve as the original. I know that I have a right to obtain a copy of this consent form if I request one.

Signature:	Date:
Relationship to patient:	

ARKANSAS FAMILIES FIRST

Your Information. Your Rights. Our Responsibilities.

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!**

Your Rights: When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- **Get a copy of health and claims records**. You can ask to see or get a copy of your health and claims records and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health and claims records, usually within 30 days of your request. We [may] charge a reasonable, cost-based fee.
- **Ask us to correct health and claims records.** You can ask us to correct your health and claims records if you think they are incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- **Request confidential communications.** You can ask us to contact you in a specific way (for example, home, cell or office phone) or to send mail to a different address. We will consider all reasonable requests, and must say "yes" if you tell us you (or your child) would be in danger if we do not.
- **Ask us to limit what we use or share.** You can ask us **NOT** to share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Get a list of those with whom we've shared information.** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make.) We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within twelve (12) months.
- **Get a copy of this privacy notice.** You can ask for a paper copy of this notice at any time, even if you agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you.** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated.** You can complain if you feel we have violated your rights by letting us know immediately. You can file a complaint with the U.S. Department of Health & Human Services Office for Civil Rights by sending a letter to: 200 Independence Ave., S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. We will not retaliate against you for filing a complaint.

Your Choices: For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in payment for care
- Share information in a disaster relief situation
- Contact you (in writing) about services that may be beneficial or of an interest to you

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health and/or safety.

We will **never** share your information for marketing purposes or sell your information unless you give us written permission.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

- Help manage the health care treatment you receive. We can use your health information to make decisions about the provision, coordination or management of your care, including analyzing or diagnosing your condition and determining the appropriate treatment.

- Run our organization. We can use and disclose your information to run our organization and contact you when necessary. For example: We may use health information to develop better services for our patients. From time to time, you may receive a letter from us informing you of services that may be of interest or benefit to you. If you do not want to receive these notices, please let us know.

- Pay for your health services. We can use and disclose your health information to your insurance plan to coordinate payments for services received. We contract with Arkansas Therapist Connection for the management of our billing and electronic health records.

- We may disclose your health information to your health plan sponsor for plan administration.

How else can we use or share your health information? We are allowed or required to share your information in other ways—usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

- Help with public health and safety issues. We can share information about you for certain situations such as: preventing disease, reporting adverse reactions to medications, reporting suspected abuse, neglect, or domestic violence, or preventing or reducing a serious threat to anyone's health or safety.

- Comply with the law. We will share information about you if state or federal laws require it, including the Department of Health & Human Services if it wants to see that we're complying with federal privacy law.

- Respond to organ and tissue donation requests and work with a medical examiner or funeral director. We can share information with a coroner, medical examiner, or funeral director when an individual dies.

- Address workers' compensation, law enforcement, and other government requests. We can use or share health information about you: for workers' compensation claims, for law enforcement purposes or with a law enforcement official, with health oversight agencies for activities authorized by law, and for special government functions such as military, national security, and presidential protective services.

- Respond to lawsuits and legal actions. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.

- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.

- We must follow the duties and privacy practices described in this notice and give you a copy of it.

- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if change your mind.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, on our web site, and we will mail a copy to you. The effective date of this notice is February 21, 2017.

This Notice of Privacy Practices applies to the following organizations: Arkansas Families First, LLC.

If you have questions or concerns regarding the use, disclosure, or privacy of your health information, please do not hesitate to let us know. You may contact Mary Ekdahl or Adam Benton by phone at 501-812-4268 or via email at admin@arfamiliesfirst.com.