Alliance Behavioral Health Integrated

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Primary Care New Patient Intake Packet

Patient Instructions

Please complete these forms before your scheduled appointment. Completed forms may be submitted through the secure website upload option, brought with you to your appointment, or completed upon arrival at the clinic. For your privacy, please do not email completed forms unless you have been instructed to use a secure or encrypted email method. Standard email may not be secure for personal health information.

Using the Additional Details Page

Some questions may not provide enough space for your answer. If you need more room, check the box marked See Additional Details page next to that section and complete the Additional Details Continuation Page in this packet. Print additional copies if needed.

Submission Options

- Upload completed forms through the secure website upload option, if available.
- Bring printed copies with you to your scheduled appointment.
- Arrive early and complete forms at the clinic if you are unable to complete them ahead of time.
- Email forms only if ABHI gives you instructions for a secure or encrypted email method.

Please Bring

- Photo identification
- Insurance card(s), if applicable
- Medication list or medication bottles
- Any relevant discharge paperwork, referral documents, or medical records

Alliance Behavioral Health Integrated

New Patient Registration & Demographics Form

Patient Information

[ ] See Additional Details page

Legal First Name _____ Middle Name _____ Legal Last Name _____

Preferred Name _____ Date of Birth _____ Phone Number _____

Email Address _____ Preferred Language _____

Street Address _____

City _____ State _____ ZIP Code _____

Preferred Contact Method

[ ] Phone [ ] Text [ ] Email [ ] Mail

Communication Preferences

[ ] Yes, voicemail permitted [ ] No voicemail

[ ] Yes, appointment reminders by text [ ] No text reminders

Demographics

[ ] See Additional Details page

These questions support patient-centered care and may be required for reporting, quality, or insurance purposes. You may decline to answer any optional demographic question.

Sex Assigned at Birth

[ ] Male [ ] Female [ ] Intersex [ ] Prefer not to answer

Gender Identity _____ Sexual Orientation _____

Race / Ethnicity _____ Marital Status _____

Emergency Contact

[ ] See Additional Details page

First Name _____ Last Name _____ Relationship _____

Phone Number _____ Alternate Phone _____

Pharmacy Information

[ ] See Additional Details page

Preferred Pharmacy Name

_____

Pharmacy Phone

_____

Pharmacy Address or Cross Streets

_____

Acknowledgment

I certify that the information provided above is true and accurate to the best of my knowledge. I agree to notify ABHI if my contact, insurance, pharmacy, or emergency contact information changes.

Patient / Legal Guardian Signature

_____

Date

_____

Relationship to Patient, if applicable

_____

Printed Name

_____

Alliance Behavioral Health Integrated

Primary Care Medical History Form

Reason for Visit

[ ] See Additional Details page

Reason for Today's Visit

_____

Primary Care Provider, if any _____

Referring Provider, if any _____

Current Medications

[ ] See Additional Details page

Medication Name	Dose	Frequency	Prescribing Provider
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies

[ ] See Additional Details page

[ ] No known drug allergies

[ ] Food allergy

[ ] Medication allergy

[ ] Environmental/other allergy

Allergy and reaction details

_____

Medical History

[ ] See Additional Details page

[ ] High blood pressure

[ ] High cholesterol

[ ] Asthma / COPD

[ ] Kidney disease

[ ] Seizures

[ ] Cancer history

[ ] Diabetes

[ ] Heart disease

[ ] Thyroid condition

[ ] Liver disease

[ ] Stroke / TIA

[ ] Chronic pain

[ ] Mental health condition
[ ] Pregnancy or possible pregnancy
[ ] Substance use history
[ ] Other

Other conditions or details

_____

[ ] See Additional Details page

Surgical / Hospital History

[ ] See Additional Details page

Prior surgeries or hospitalizations

_____

Family Medical History

[ ] See Additional Details page

Family history of major medical or behavioral health conditions

_____

Social History & Support Needs

[ ] See Additional Details page

[ ] Never used tobacco/nicotine
[ ] Current tobacco/nicotine use
[ ] Former tobacco/nicotine use
[ ] Alcohol use
[ ] No alcohol use
[ ] Substance use concern
[ ] Housing concern
[ ] Transportation concern
[ ] Food insecurity
[ ] Employment or benefits concern

Additional information you want your provider to know

_____

[ ] See Additional Details page

Patient / Legal Guardian Signature

_____

Date

_____

Alliance Behavioral Health Integrated

Additional Details Continuation Page

Use This Page If More Space Is Needed

If you checked any box marked See Additional Details page, identify the form section or question below and provide the additional information. Print additional copies of this page if more space is needed.

Patient Name _____ Date of Birth _____

Detail Entry 1

Form / Section / Question _____ Date _____

Additional information

_____

_____

_____

_____

Detail Entry 2

Form / Section / Question _____ Date _____

Additional information

_____

_____

_____

_____

Detail Entry 3

Form / Section / Question _____ Date _____

Additional information

_____

_____

_____

_____

Detail Entry 4

Form / Section / Question _____ Date _____

Additional information

_____

Alliance Behavioral Health Integrated

Insurance & Financial Responsibility Form

Please provide the most current insurance information and bring your insurance card(s) to your appointment. Insurance verification is not a guarantee of payment.

Primary Insurance

Insurance Company _____ Member ID _____ Group Number _____

Policyholder Name _____ Policyholder Date of Birth _____ Relationship to Patient _____

Employer Name, if applicable _____ Employer Phone, if applicable _____

Secondary Insurance

Insurance Company _____ Member ID _____ Group Number _____

Policyholder Name _____ Policyholder Date of Birth _____ Relationship to Patient _____

Financial Responsibility & Assignment of Benefits

I authorize Alliance Behavioral Health Integrated to bill my insurance carrier or other payer for services provided. I authorize payment of medical benefits directly to Alliance Behavioral Health Integrated when applicable.

I understand that I am responsible for copayments, deductibles, coinsurance, non-covered services, denied claims, services not authorized by my payer, and balances not paid by insurance. I agree to provide accurate insurance and billing information and notify ABHI of any changes.

ABHI may contact me regarding appointment scheduling, billing, insurance, referrals, care coordination, or account-related matters using the contact information I provide, consistent with applicable privacy laws and communication preferences.

For security and privacy, Social Security Numbers should not be sent through standard email or unsecured website forms unless specifically required and collected through an approved secure process.

Patient / Legal Guardian Signature _____ Date _____

Alliance Behavioral Health Integrated

General Consent for Treatment, Services & Telehealth

I voluntarily consent to receive healthcare services from Alliance Behavioral Health Integrated. Services may include primary care, preventive care, medical evaluation, laboratory orders, medication management, behavioral health services, psychiatric evaluation, psychotherapy, care coordination, referrals, telehealth services, and other services recommended by my provider.

I understand that healthcare is not an exact science and no guarantee has been made regarding treatment outcomes.

Informed Consent

I understand that informed consent is an ongoing communication process between me and my provider. I have the right to ask questions and receive information about recommended treatment, expected benefits, reasonably foreseeable risks or side effects, alternatives, and my right to refuse or withdraw consent except where required by law or in emergencies.

Telehealth Consent, If Applicable

I understand that some services may be provided through telehealth when clinically appropriate. I understand telehealth may involve audio, video, electronic communication, or remote monitoring tools. Benefits may include improved access to care, and limitations may include technology failure, privacy risks, or the need for in-person care. I may withdraw telehealth consent at any time.

Use and Disclosure of Health Information

I understand that ABHI may use and disclose my health information for treatment, payment, and healthcare operations as permitted by HIPAA and other applicable laws. This may include communication with providers involved in my care, laboratories, pharmacies, referral sources, and insurance plans as needed for care coordination and billing.

Confidentiality and Safety Exceptions

I understand that my health information is confidential and protected by state and federal law. Exceptions may include emergencies, risk of serious harm to myself or others, suspected abuse or neglect of a child, elder, or vulnerable adult, court orders, legal requirements, audits, treatment, payment, healthcare operations, and other disclosures permitted or required by law.

Patient Responsibilities

I agree to provide accurate information, participate in treatment planning, follow clinic policies, ask questions when I do not understand, keep scheduled appointments or provide timely notice of cancellation, and provide current insurance and billing information.

By signing below, I acknowledge that I have read and understand this consent, have had the opportunity to ask questions, and voluntarily agree to receive services from ABHI.

Patient / Legal Guardian Signature _____ Date _____

Relationship to Patient, if applicable _____ Printed Name _____

Staff / Witness Signature _____ Date _____

Alliance Behavioral Health Integrated

HIPAA / Notice of Privacy Practices Acknowledgment

I acknowledge that I have been offered or provided access to Alliance Behavioral Health Integrated's Notice of Privacy Practices. I understand that the Notice explains how my protected health information may be used and disclosed, and describes my rights regarding my health information.

I understand I may request a paper copy of the Notice of Privacy Practices at any time, even if I receive it electronically.

I understand that ABHI may revise its Notice of Privacy Practices as permitted or required by law and that the current Notice will be available through the clinic or website when applicable.

Patient Name _____

Date of Birth _____

Patient / Legal Guardian Signature _____

Date _____

Alliance Behavioral Health Integrated

Notice of Privacy Practices - Patient Copy

This Notice describes how medical information about you may be used and disclosed and how you can access this information. Please review it carefully.

Our Pledge Regarding Medical Information

Alliance Behavioral Health Integrated is committed to protecting your medical information. We are required by law to maintain the privacy and security of protected health information, provide you with this Notice of our legal duties and privacy practices, follow the terms of the Notice currently in effect, and notify you if a breach occurs that may have compromised the privacy or security of your information.

How We May Use and Disclose Your Information

Treatment: We may use and disclose your information to provide, coordinate, or manage your care, including sharing information with other providers involved in your treatment.

Payment: We may use and disclose your information to bill and obtain payment from you, your health plan, or another responsible party.

Healthcare Operations: We may use and disclose your information for business operations such as quality improvement, staff training, compliance, audits, licensing, and patient services.

Appointment Reminders and Care Communications: We may contact you about appointments, follow-up care, treatment alternatives, health-related benefits, or services that may interest you.

Individuals Involved in Your Care or Payment: We may share information with a family member, representative, or person involved in your care or payment when permitted by law and based on your preferences or our professional judgment.

Required or Permitted by Law: We may disclose information when required or permitted by law, including public health reporting, abuse or neglect reporting, health oversight activities, legal proceedings, law enforcement requests, workers' compensation, coroners or medical examiners, research as permitted by law, and to prevent a serious threat to health or safety.

Additional Protections

Certain information may receive additional protection under federal or state law, including certain substance use disorder treatment records, HIV/AIDS-related information, mental health records, genetic information, and other specially protected records. ABHI will follow applicable requirements when using or disclosing these records.

Your Rights

You have the right to request access to inspect or obtain a copy of your medical records, request an amendment to information you believe is incorrect or incomplete, request an accounting of certain disclosures, request restrictions on certain uses or disclosures, request confidential communications, receive a paper copy of this Notice, and file a complaint if you believe your privacy rights have been violated.

To exercise these rights, contact ABHI using the contact information listed on this form. You may also file a complaint with the U.S. Department of Health and Human Services. ABHI will not retaliate against you for filing a complaint.

Marketing, Sale of Information, and Other Uses

ABHI will not use or disclose your information for marketing purposes or sell your protected health information without your written authorization when authorization is required by law. Uses and disclosures not described in this Notice will be made only with your written authorization when required. You may revoke an authorization in writing except to the extent ABHI has already relied on it.

Contact

For questions about this Notice or privacy practices, contact Alliance Behavioral Health Integrated at (623) 401-2882 or visit alliancebhi.com.

Alliance Behavioral Health Integrated

Authorization for Release of Information (ROI)

This authorization permits Alliance Behavioral Health Integrated to release, obtain, or exchange health information as described below. Please complete all applicable sections.

Patient Information

Patient Name _____ Date of Birth _____ Phone Number _____

Authorization Direction

[ ] Release information TO the person/agency listed below

[ ] Obtain information FROM the person/agency listed below

[ ] Exchange information WITH the person/agency listed below

Person, Provider, or Agency

Name of Person / Provider / Agency _____

Address _____ Phone _____ Fax / Email _____

Information Authorized for Disclosure

[ ] Medical records

[ ] Medication list

[ ] Diagnosis

[ ] Progress notes

[ ] Substance use assessment or treatment records, if applicable

[ ] Assessment information

[ ] Other: _____

[ ] Primary care records

[ ] Lab results

[ ] Treatment plan

[ ] Psychiatric evaluation

[ ] Billing / insurance information

[ ] Recommendations

Purpose of Disclosure

[ ] Treatment coordination

[ ] Legal / court / probation requirement

[ ] Continuity of care

[ ] Insurance / payment

[ ] Patient request

[ ] Other: _____

Date Range and Expiration

Records From _____ Records To _____

[ ] This authorization expires in 90 days

[ ] This authorization expires in 1 year

[ ] This authorization expires on this date/event: _____

Acknowledgment and Understanding

I understand that I may revoke this authorization at any time by submitting a written request to ABHI. Revocation will not apply to information already released before ABHI receives my written revocation. I understand that I have the right to receive a copy of this authorization.

I understand that information disclosed under this authorization may be subject to redisclosure by the recipient unless protected by applicable law. Certain substance use disorder treatment records may be subject to additional federal protections and disclosure requirements.

Patient / Legal Guardian Signature _____ Date _____

Relationship to Patient, if applicable _____ Printed Name _____

Staff / Witness Signature _____ Date _____

Alliance Behavioral Health Integrated

Patient Rights, Grievance & Advance Directive Acknowledgment

ABHI respects your rights as a patient and is committed to providing care with dignity, respect, privacy, and consideration of your individual needs. These rights also apply to legally authorized representatives when applicable.

Patient Rights

You have the right to be treated with dignity, respect, and consideration; receive care free from discrimination; participate in treatment planning and decision-making; receive information about diagnosis and treatment options; consent to or refuse treatment except where required by law or in emergencies; receive privacy in treatment and personal care; request access to your medical records consistent with applicable law; receive referrals if ABHI cannot provide necessary services; refuse participation in research or experimental treatment; and file a grievance or complaint without fear of retaliation.

Protection from Harm

Patients have the right to be free from abuse, neglect, exploitation, coercion, manipulation, sexual abuse, assault, retaliation, and misappropriation of personal or private property by staff, employees, volunteers, or students.

Grievance / Complaint Process

I acknowledge that I have been informed of the grievance process. I understand that I may submit a complaint or grievance verbally, in writing, or through the front desk or administrative team. Grievances may include concerns about care, treatment, staff behavior, privacy, billing, or facility operations. ABHI will review grievances and respond through its administrative process.

Advance Directive Notification

I have been informed of my right to complete an Advance Directive, which may include a Living Will, Durable Power of Attorney for Healthcare, or Mental Health Care Directive. An Advance Directive allows me to make decisions about medical or psychiatric care in advance if I become unable to communicate my wishes.

[ ] I have an Advance Directive and will provide a copy

[ ] I do not currently have an Advance Directive but have been informed of my rights

[ ] I decline to complete an Advance Directive at this time

By signing below, I acknowledge that I have received or been informed of patient rights, the grievance process, and advance directive options. I have had the opportunity to ask questions.

Patient / Legal Guardian Signature _____ Date _____

Relationship to Patient, if applicable _____ Printed Name _____

Staff / Witness Signature _____

Date _____

Alliance Behavioral Health Integrated

Camera Recording Disclosure & Patient Consent

To maintain a safe and secure environment for patients, visitors, and staff, Alliance Behavioral Health Integrated may use security camera surveillance in designated public or common areas of the facility.

Notice of Video Surveillance

- Cameras may be located in lobby, entry, hallway, exterior, and common areas only.
- Cameras are not placed in treatment rooms, exam rooms, restrooms, or other private care areas.
- Recordings are stored securely and accessed only by authorized personnel when necessary.
- Recordings are used for safety and security purposes and are not part of the medical record unless specifically used or retained for a documented incident or legal requirement.

Patient Acknowledgment

I acknowledge that I have been informed of the presence of security camera surveillance in designated common areas of ABHI. I understand that the purpose of surveillance is to promote safety and security and help prevent incidents such as theft, vandalism, or other safety concerns. I understand that no cameras are placed in treatment rooms, exam rooms, restrooms, or other private care areas.

Patient / Legal Guardian Signature _____ Date _____

Relationship to Patient, if applicable _____ Printed Name _____

Staff / Witness Signature _____ Date _____