HighlandSprings™
A VALLEY SPECIALTY CLINIC

APPLICATION FOR SERVICES

DATE: _____
CLIENT ID #: _____
BIRTHDATE: _____
NAME: _____
SS #: _____

PH # (C): _____ **PH # (H):** _____
ADDRESS: _____ **CITY:** _____
COUNTY: _____ **STATE:** _____ **ZIP:** _____ **EMAIL:** _____
SEX: ☐ Female ☐ Male ☐ Transgender **GENDER IDENTITY:** ☐ Transgender ☐ Non-Binary
RACE: ☐ Alaskan Native ☐ American Indian ☐ Asian ☐ Black/African-American ☐ Pacific Islander ☐ White ☐ Other
ETHNICITY: ☐ Dominican ☐ Hispanic/Latino ☐ Not Hispanic or Latino
MARITAL STATUS: ☐ Divorced ☐ Married ☐ Never Married ☐ Separated ☐ Widowed

HOW DID YOU HEAR ABOUT US?

NAME/CLINIC: _____ **PH #:** _____

EMERGENCY CONTACT

NAME: _____ **PH #:** _____ **RELATIONSHIP:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____
EMAIL: _____

INSURANCE INFORMATION

INSURANCE NAME: _____ **PLAN:** _____
POLICY OR ID #: _____ **PH #:** _____
POLICY HOLDER NAME: _____ **PH #** _____ **DOB:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

INDIVIDUALS INVOLVED IN MY CARE

Highland Springs Specialty Clinic complies with the Health Information Portability and Privacy Act (HIPAA). These regulations allow us to share your Protected Health Information (PHI) with others that you consider part of your care team. This can include other healthcare providers. To release information to family, friends or any other party a signed Release of Information form is required. For additional space, request an addendum form. *You can list more on the back of the page if needed.

NAME: _____ **PH #:** _____ **RELATIONSHIP:** _____

PRIMARY CARE PHYSICIAN

INITIAL IF YOU DO NOT HAVE A PCP: ____ **NAME:** _____
CLINIC: _____ **SPECIALTY:** _____ **PH #:** _____
ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

EDUCATION/EMPLOYMENT

EDUCATION STATUS: ☐ Enrolled ☐ Not enrolled **EDUCATION LEVEL:** _____
EMPLOYMENT STATUS: _____ **EMPLOYMENT INFORMATION:** _____
MILITARY STATUS: ☐ Yes ☐ No **TOBACCO USE:** ☐ Yes ☐ No **ADVANCED DIRECTIVE:** ☐ Yes ☐ No

Applicant Name _____ ***Client Id #*** _____

Initial each item received:

_____ **PRIVACY NOTICE**

The Privacy Notice tells you how we may share your protected health information (PHI). It lets you know when your permission is required to share protected health information (PHI) with others. Please read the Privacy Notice carefully.

_____ **RIGHTS AND RESPONSIBILITIES**

This describes your rights and responsibilities as a client.

EMERGENCY MEDICAL CARE

I consent to receive first aid and emergency treatment. This would be if I have an accident, injury, illness or other medical emergency. I understand this applies only during treatment at Highland Springs Specialty Clinic.

CONSENT

I certify the above information is accurate and complete. I consent to treatment and testing / assessment at Highland Springs Specialty Clinic and with Telehealth. I understand testing includes, but is not limited to: intellectual, cognitive, developmental and functional testing.

I hereby consent to have Highland Springs Specialty Clinic staff to communicate with me, where appropriate via e-mail and text messages regarding the following aspects of my medical care and treatment (*prescriptions, appointments and billing*). I understand that e-mail and text messages are not a confidential method of communication. I further understand that there is a risk with these means of communication between my treatment team, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment that may be intercepted by third parties or transmitted to unintended parties. I also understand that any e-mail and/or text communications between my physician, clinical office staff, my other physicians or nurse practitioners and myself regarding my medical care and treatment may be printed out and made a part of my medical record. _____ ***Client Initials***

I understand that in an urgent or emergency situation I should call my provider or go to the Emergency Room and not rely on email.

Client or Parent/Guardian Signature	**Date**
Client or Parent/Guardian Printed Name	**Relationship to Client**
Staff Signature	**Date**

CLIENT FEE AGREEMENT-
CANCELLATION &
PAYMENT POLICIES

HighlandSprings™
A VALLEY SPECIALTY CLINIC

Client ID # _____

Name: _____ **DOB:** _____ **Effective Date:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone #: _____ **SS #:** _____ **Insurance:** _____

BY SIGNING THIS FORM, I AGREE TO THE FOLLOWING:

- I understand that payment/co-pays are due at the time of service for ALL services.
- I understand that my insurance may not cover all services provided, and that I will be expected to pay for uncovered services at the self-pay rates.
- I understand that Highland Springs Specialty Clinic are not participating providers for Medicaid and that I am opting out of any Medicaid coverage, including retroactive Medicaid coverage for any services rendered. Highland Springs will not bill any services to the following insurance carriers:
    a) Medicaid
    b) Medicare/Medicaid
    c) Molina Advantage Plans/Medicaid

_____ **I acknowledge that I am NOT covered by one of the Insurance carriers listed above or that I may NOT become retroactively eligible at any time during my treatment.**

- I further understand that if I become Medicaid eligible during my treatment at a HSSC clinic and wish to utilize my Medicaid coverage. I will be referred to a Medicaid provider facility and discharged from treatment at HSSC Clinic
- I also understand that all services rendered at HSSC clinic and wish to utilize my Medicaid coverage.
- I understand that Highland Springs Specialty Clinic does not bill Medicaid for services rendered and that I am opting out of any Medicaid coverage, including retroactive Medicaid coverage for any services rendered.
- I understand that Highland Springs Specialty Clinic will bill my health insurance or other payer the full cost of services for all covered treatment and services I receive.
- I understand that I must notify Highland Springs Specialty Clinic of any changes to my insurance or coverage and that by failing to do so I will be liable for the self-pay rates for all services provided.
- I understand that if my insurance is terminated and I am not covered on the date of service that I will be charged the self-pay rates for all services I have received after the insurance termination date.
- I agree to send Highland Springs Specialty Clinic all payments from insurance or third-party payers that I have received directly for services I have received from Highland Springs Specialty Clinic and that failure to do so will result in me being liable for such payments.
- I understand that Highland Springs Specialty Clinic does NOT accept checks
- I understand that Highland Springs Specialty Clinic has the right to refuse to provide additional services and send my account to a collection agency for resolution after 90 days of non-payment for services.
- If my account is sent to a collections agency, I understand that I am liable for all costs incurred by Highland Springs Specialty Clinic including court filings, constable fees, attorney fees, and interest accumulation at the legal rate on the unpaid balance until the balance is **paid in full**.
- I understand that there are fees associated with missed appointments that are not cancelled/rescheduled with 24 hours' notice.

The fee is $50.00 per missed appointment.

Authorizations

- I authorize my insurance company or third-party payer to make payments, otherwise payable to me, directly to Highland Springs Specialty Clinic. In the event that the benefits paid exceed the total cost of services Highland Springs Specialty Clinic will be responsible for issuing a refund.
- I authorize Highland Springs Specialty Clinic to pre-authorize services with my insurance company and to appeal, on my behalf, any decision made by the insurance company regarding payment.
- I authorize Highland Springs Specialty Clinic to disclose personal health information to my insurance company or any other entity responsible for paying for my treatment in order to obtain reimbursement.

This fee agreement covers all services provided by Highland Springs Specialty Clinic including mental health and substance abuse treatment.

Client/Parent Signature	**Date**
Client/Parent Printed Name	**Relationship to Client**
Staff Signature	**Date**