ALT RECOVERY GROUP2 LLC

REGISTRATION & INSURANCE VERIFICATION FORM

ASSIGNMENT OF BENEFITS

(Please Print)

Today's date:	MRN #:

PATIENT INFORMATION

Social Security Number *	Patient's First name *	M.I.	Last *	Birth date *	Gender *
				/ /	

Street address *	Cell phone #	Home phone #
	( )	( )

City *	State *	ZIP Code *	Emergency Contact Name **NOT** living with you* & **Relationship to You**	Emergency phone *	Emergency address *

Email:	Legal name (if different than above)	Marital status (circle one)
		Single / Mar / Div / Sep / Widow(er)

How did you hear about us? **RACE:**

WEIGHT: **HEIGHT:** **HAIR:** **EYES**:

Employment Status

Employment * ☐Unemployed ☐Disabled ☐School ☐ Homemaker ☐Other: _____

Employer:	Employers address:	Employer phone #
		( )

PAYMENT INFORMATION

Self-Payment (No Insurance): ❑ Cash ❑ Debit/Credit *** If Self Pay SIGN FINANCIAL AGREEMENT ***

California Medi-Cal Information

I have Medi-Cal ❑ Yes ❑ No (Please check below which Medi-Cal assigned or if only state Medicaid):

❑ L.A. Care ❑Health Net ❑ Molina

❑ Blue Cross Blue Shield ❑ Medi-Cal (FFS) ❑ OTHER_____

Medi-Cal ID #: _____Group #: _____

Primary Insurance (OTHER THAN MEDICAID)

Insurance Plan: **Name of Policyholder:**

Policyholder Address:
(If not same as above) Street City State Zip code

Group#: ID#:

Policy holder DOB: Policyholder Phone: Policy holder SSN#:

MEDICARE (ALT ACCEPTS MEDICARE ONLY IF YOU HAVE FULL MEDI-CAL BENEFITS}

Insurance Plan: **Name of Policyholder:**

Policyholder Address:
(If not same as above) Street City State Zip code

Group#: ID#:

Policy holder DOB: Policyholder Phone: Policy holder SSN#:

Responsibility/Release Statement

The above information is true to the best of my knowledge, I authorize ALT RECOVERY GROUP LLC., to verify insurance benefits and be paid directly by insurance companies. I authorize ALT RECOVERY GROUP or insurance company to release any information required to process my claims. I authorize ALT RECOVERY GROUP LLC, to obtain a CALIFORNIA prescription monitoring report. I understand that I am responsible for any co pays, co-insurance or deductibles not paid by insurance. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that records concerning mental health services I receive are protected by federal law under HIPAA. I understand information received cannot be re-disclosed to an additional 3rd party. In addition, I understand I may revoke this consent at any time except where the entity originally permitted to make the disclosure has already acted in the reliance of the consent, and that in any event this consent expires automatically one month following the date I am discharged from ALT RECOVERY GROUP, LLC. or on _____ (specify date, not more than two years from signing).

Patient/Guardian signature Date

Eligibility Date: _____ Verified: _____

YOUR INFORMATION

LAST NAME: _____ FIRST NAME: _____

DATE OF BIRTH: _____ PT ID #: _____ _____

ADDRESS: _____ _____

TELEPHONE NUMBER: _____

Person/Organization Providing the Information Person/Organization Receiving the Information Name:

Address: City/State/Zip: Phone #: Fax Number:

Name: ALT Recovery Group 2 LLC Address: 20946 Devonshire St., Suite 100 City/State/Zip: Chatsworth, CA 91311 Phone #: 818-626-8053 Fax Number: 818-626-8415

42 CFR § 2.32 - Prohibition on re-disclosure 45 C.F.R §§164.508(c)(1)(ii) and (iii); CA Civil Code §§56.11(c) and(f)

Description of the Information to be Released (Provide a detailed description of the specific information to be released) 42 CFR § 2.32 - Prohibition on re-disclosure 45 C.F.R. §§164.508(c)(1)(i); CA Civil Code §§56.11(d) and (g)

□ Most recent Labs □ MD Notes □ Discharge Summary □ HIV or AIDS Information □ Alcohol/Drug Information □ Prescribed Medication List □ Mental Health/Behavioral Health □ Genetic Testing □ Dosing History Provider Approved: Date: Provider Denied: Date: Other:

For the following period: From _____ (date) to _____(date)

Description of the Purpose and Limitations for the Use or Release of the Information (Indicate how information will be used) 42 CFR § 2.32 - Prohibition on re-disclosure 45 C.F.R. §§164.508(c)(1)(iv)

The Information will not be used for any purpose other than its intended use.

This authorization for release of information will expire in 12 months from the date signed or as otherwise specified:

_____ (date)

[45 C.F.R §§164.508(c)(v); CA Civil Code §56.11(h)]

AUTHORIZATION FOR RELEASE OF INFORMATION Revised 5.15.2019

20946 Devonshire St., Suite 100

Chatsworth, CA 91311

Tel. 818-626-8053 Fax. 818-626-8415

Patient Name: _____ DOB: _____ ID#: _____

I understand that:

➢ I authorize the use and/or disclosure of my individually identifiable health information as described above for

the purpose listed. I understand that this authorization is voluntary. ➢ I have the right to cancel this authorization at any time by sending a signed notice to ALT Recovery Group at

20946 Devonshire St., Suite 100, Chatsworth, CA 91311. The authorization will cease on the date my valid revocation request is received. ➢ The Notice of Privacy Practices provides instructions for me should I choose to revoke my authorization and

includes limitations on my revocation. ➢ My treatment, payment, enrollment or eligibility for benefits will not be affected if I do not sign this

authorization. ➢ Under California law, the recipient of my medical information is prohibited from disclosing the information,

except with a written authorization or as specifically required by permitted law. ➢ If the organization or person I have authorized to receive the information is not a health plan or health care

provider; the released information may no longer be protected by federal privacy regulations ➢ I have the right to receive a copy of this authorization. ➢ Records and copies obtained by recipient relating to outpatient psychotherapy care shall be returned to

disclosing organization or destroyed by recipient at the expiration date of this authorization except those obtained for treatment and diagnosis purposes. ➢ The purpose of the disclosures authorized in this consent is to enable the above parties to evaluate my need for services and to provide and coordinate those services. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that records concerning mental health services I receive are protected by federal law under HIPAA. ➢

Patient Signature: Date:

Patient’s (Personal Representative Signature: Relationship: Date:

ID Obtained and All information Verified by ALT Recovery Group Staff:

Staff Signature: _____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION Revised 5.15.2019

CONFIDENTIALITY AND CONSENT TO TREAT

Patient Name: _____ Date: _____

Confidentiality

I understand that if am Medi-Cal eligible, ALT Recovery Group will be submitting billings, including my diagnosis for reimbursement of therapeutic services. In addition, your name and Medi-Cal number will be given to Toxicology for urinalysis testing, and to San Diego Reference Laboratory for blood tests that are required while you are in treatment at ALT Recovery Group. This information will be released in compliance with federal regulations governing mental health and substance abuse patient records.

Your confidentiality regarding mental health and/or substance abuse records is legally protected, and we may not disclose any information identifying you as a mental health or an alcohol and drug abuser unless the following occur:

• You consent in writing

• Disclosure is ordered by a court or court order

• Information is needed by medical personnel treating you in an emergency

• You commit or threaten to commit a crime either at the clinic, or against any person who works for the clinic

• In our assessment you become harmful to yourself or others

• We suspect child abuse or neglect (we are required by state law to report)

Consent to Treat

I understand that I will be informed of my counselor's credentials, degrees, and licenses and have also read and understand mu rights as a patient at ALT Recovery Group.

I consent to ALT Recovery Group provide ongoing assessment and treatment for my behavioral, emotional, social and educational problems. I understand that my care is provided by a team of professionals under the guidance and supervision of a licensed clinician. I understand that my assessment may include psychiatric and psychological questionnaires and evaluations, physical and neurological evaluations, educational and vocational evaluation/instruction to assess skills and career goals, and ongoing urine and breath tests for drugs and alcohol. Females will also be tested for pregnancy on admission and prior to any decrease in medication.

I understand that I can end my treatment at any time and that my referring agency will be notified of my termination and that this could result in consequences for me if I am court ordered to treatment or for an evaluation.

I hereby authorize and give my voluntary consent to ALT Recovery Group to be involved in mental health and substance abuse treatment. I willfully enter this treatment and understand my responsibility in working towards my treatment goals. I have been offered a copy of this form.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

CONSENT TO PARTICIPATION IN OPIOID PHARMACOTHERAPY TREATMENT

Patient's Name: _____ DOB: _____ PT ID#: _____

I hereby authorize and give voluntary consent to the ALT Recovery Group and its medical personnel to dispense and administer opioid pharmacotherapy (including methadone or buprenorphine) as part of the treatment of my addiction to opioid drugs. Treatment procedures have been explained to me, and I understand that this will involve my taking the prescribed opioid drug at the schedule determined by the program physician, or his/her designee, in accordance with federal and state regulations.

It has been explained that, like all other prescription medications, opioid treatment medications can be harmful if not taken as prescribed. I further understand that opioid treatment medications produce dependence and, like most other medications, may produce side effects. Possible side effects, as well as alternative treatments and their risks and benefits, have been explained to me.

I understand that it is important for me to inform any medical provider who may treat me for any medical problem that I am enrolled in an opioid treatment program so that the provider is aware of all the medications I am taking, can provide the best possible care, and can avoid prescribing medications that might affect my opioid pharmacotherapy or my chances of successful recovery from addiction.

I understand that I may withdraw voluntarily from this treatment program and discontinue the use of the medications prescribed at any time. Should I choose this option, I understand I will be offered medically supervised withdrawal.

For Female Patients of Childbearing Age: There is no evidence that methadone pharmacotherapy is harmful during pregnancy. If I am or become pregnant, I understand that I should tell my medical provider right away so that I can receive appropriate care and referrals. I understand that there are ways to maximize the healthy course of my pregnancy while I am in opioid pharmacotherapy.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Fee Guidelines_ALT2_5.08.19

FEE GUIDELINES

Patient Name: _____ DOB: _____ ID#: _____

The following are guidelines related to the payment of fees for substance abuse services at ALT Recovery Group. You will be asked to sign this form acknowledging that you have been informed of the cost of your services at ALT Recovery Group and told when and how fees will be collected.

The following are rules regarding fee payments.

WE CANNOT MAKE CHANGE. Any overpayment will be added as a credit to your account.

INTAKE FEE IS _____. This fee includes doctor time, lab testing, counseling, and dosing until the following Monday. In addition, you will be responsible for the first week payment of the week which will be pro-rated.

TRANSFERS – If you are transferring from another clinic you will need to pay the first week's fee and a $70 transfer fee when you come in to begin dosing. This money will be applied to your account and pays for your appointment with the doctor, and your first week in treatment.

RESTARTS:

If you have been absent for 3-6 days, you will be charged a $15.00 restart fee.

If you have been absent for 7-29 days, you will be charged a $70.00 restart fee in addition to being caught up in your fees. Exceptions are on a case by case basis.

FEES ARE DUE EVERY MONDAY OF THE MONTH – THE WEEKLY RATE FOR FEES IS _____/week.

All fees need to be paid on the due date or you will be placed on a fee taper that decreases your methadone dose by either 10% or 10mg/day, depending on your current dose. Payment arrangements will be made on a case by case basis. IF YOU CANNOT PAY THE WEEKLY RATE

Patient Name: _____ DOB: _____ ID#: _____

ALT Recover Group Fee Guidelines (cont.)

YOU CAN CHOOSE TO GO TO THE DAILY RATE OF _____/DAY. YOU WILL BE CHARGED FOR EVERY DAY OF THE WEEK, INCLUDING SUNDAY FOR A TOTAL OF ___/WEEK. IF YOU CANNOT PAY THE _____FOR THE DAY YOU WILL BE TAPERED DOWN. YOU CAN RETURN TO THE _____/WK RATE THE NEXT MONDAY.

There are no refunds for fees that have already been paid. If you drop out of treatment you will have any remaining fees applied to a credit.

ALT Recovery Group has been assigned a Medi-Cal provider number and we will notify you when we are able to begin billing Medi-Cal for the cost of your treatment services.

WHEN WE CAN BILL MED-ICAL:

If you have Medi-Cal, you will be responsible for paying for any services you receive at ALT Recovery Group if your Medi-Cal lapses or you are no longer eligible for Medi-Cal. You must sign a Medication Verification Form with your counselor for the program to verify your benefits.

By signing below, I acknowledge that I have been given information regarding the cost of my treatment at ALT Recovery Group, how the fees are collected, and what the consequences are for not paying my fees. I have also been informed that when Medi-Cal starts paying for my treatment I will be responsible for any services I receive if I become ineligible for Medi-Cal.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Fee Guidelines_ALT2_5.08.19

ALT RECOVERY GROUP2 LLC REGISTRATION & INSURANCE VERIFICATION FORM
ASSIGNMENT OF BENEFITS (Please Print) Today's date: MRN #:

P A T I E N T I N F O R M A T I O N Social Security Number * Patient's First name * M.I. Last * Birth date * Gender *

/ /

How did you hear about us? RACE:

WEIGHT: HEIGHT: HAIR: EYES:

Employment Status

Employment * □Unemployed □Disabled □School □ Homemaker □Other:
_____

Employer: Employers address: Employer phone #

PAYMENT INFORMATION Self-Payment (No Insurance): ❑ Cash ❑ Debit/Credit * If Self Pay SIGN FINANCIAL AGREEMENT *

California Medi-Cal Information I have Medi-Cal ❑ Yes ❑ No (Please check below which Medi-Cal assigned or if only state Medicaid): ❑ L.A. Care ❑Health Net ❑ Molina ❑ Blue Cross Blue Shield ❑ Medi-Cal (FFS) ❑ OTHER_____ Medi-Cal ID #:
_____Group #: _____

Primary Insurance (OTHER THAN MEDICAID)

Insurance Plan: Name of Policyholder:

Policyholder Address:

(If not same as above) Street City State Zip code

Group#: ID#:

Policy holder DOB: Policyholder Phone:

Policy holder SSN#:

MEDICARE (ALT ACCEPTS MEDICARE ONLY IF YOU HAVE FULL MEDI-CAL BENEFITS}

Insurance Plan: Name of Policyholder:

Policyholder Address:

(If not same as above) Street City State Zip code

Group#: ID#:

Policy holder DOB: Policyholder Phone:

Policy holder SSN#:

Responsibility/Release Statement

The above information is true to the best of my knowledge, I authorize ALT RECOVERY GROUP LLC., to verify insurance benefits and be paid directly by insurance companies. I authorize ALT RECOVERY

GROUP or insurance company to release any information required to process my claims. I authorize ALT RECOVERY GROUP LLC, to obtain a CALIFORNIA prescription monitoring report. I understand that I am responsible for any co pays, co-insurance or deductibles not paid by insurance. I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that records concerning mental health services I receive are protected by federal law under HIPAA. I understand information received cannot be re-disclosed to an additional 3rd party. In addition, I understand I may revoke this consent at any time except where the entity originally permitted to make the disclosure has already acted in the reliance of the consent, and that in any event this consent expires automatically one month following the date I am discharged from ALT RECOVERY GROUP, LLC. or on _____ (specify date, not more than two years from signing).

Patient/Guardian signature Date

Eligibility Date: _____ Verified: _____

City * State * ZIP Code * Emergency Contact Name NOT living with

you* & Relationship to You

Street address * Cell phone # Home phone #

( ) ( )

Email: Legal name (if different than above) Marital status (circle one)

Single / Mar / Div / Sep / Widow(er)

Emergency phone * Emergency address *

( )

I, _____, herby authorize, ALT Recovery Group to disclose information as permitted by law, to include my name, birthday, sex, ethnicity, weight, height, eye color, hair color, distinguishing features, and any A.K.A. to methadone clinics within a radius of 50 miles of this treatment program. I understand the purpose for such disclosure is the prevention of multiple methadone maintenance or outpatient detoxification program enrollment, and that my photograph may be used in multiple reviews. This consent shall remain in effect as long as I am a patient on this program (sec2.34 (H) Federal regulations) and may be subject to revocation at any time except to the extent that the program has already acted in reliance on it.

Patient Full Name: _____ DOB _____ /_____ /_____

Social Security # _____-_____-_____ A.K.A. _____

Hair color _____ Eye color _____ Height _____ Weight _____Ethnicity_____

Mother's maiden name_____Distinguishing marks or tattoos_____

The following clinic has been sent a fax to check if the above-named patient is on their methadone program. ALT Recovery reserves the right to consult any prior treatment program to determine patient standings and reason for leaving, please initial _____.

Date:_____ Clinic called: _____ verified that the above named patient (is NOT ___ IS ___) on their methadone program – spoke to _____

Date:_____ Clinic called: _____ verified that the above named patient (is NOT ___ IS ___) on their methadone program – spoke to _____

Date:_____ Clinic called: _____ verified that the above named patient (is NOT ___ IS ___) on their methadone program – spoke to _____

□ YOUR FACILITY NAME/ STAMP: _____ Verified that the above-named patient IS NOT □ IS □ on their methadone program.

If yes, date last dosed: _____ /_____ /_____, medication dosage: _____

Patient Statement: I am not receiving methadone from another program. I understand that if I do not acknowledge this by my signature, I will not be admitted to ALT Recovery Group for treatment.

Patient Notification: This program is required to notify each patient prior to admission that ALT Recovery Group cannot provide methadone to a patient who is simultaneously receiving methadone from another program.

Patient Signature: _____ Date: _____

Witness Signature: _____Date: _____

Confidentiality of Records: This information has been disclosed to you from records whose confidentiality is protected by Federal Law, Federal regulations (42 CFR, Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT enough for this purpose.

20946 Devonshire St., Suite 100 Chatsworth, CA 91311 Tel - 818-626-8053 Fax - 818-626-8415