BayPointe Hospital Admission Paperwork Fax Cover Sheet

Admission Paperwork Instructions

- **Completed Admission Paperwork** must include:
    1. **Legal guardian initials and signatures** on all appropriate spaces in the included paperwork
    2. Copy of **legal guardian's photo ID**
    3. Copy of **patient's insurance information** (front and back)
- Please fax completed paperwork and photocopies to **866-357-1154** or securely email completed paperwork and photocopies to **ManagedCare@altapointe.org**

Confirmation of Admission Paperwork

- A **BayPointe Admissions Clerk** will contact referring hospital once this paperwork has been received and confirmed to be completed accurately.
- Please **do not transport patient** until BayPointe has confirmed this with the referring hospital.

Referring Hospital: ____

Contact Name: ________________________ Contact Number: _______________

BayPointe Hospital | 5800 Southland Drive, Mobile, AL 36693 | www.BayPointeHospital.org
Phone: (251) 661-0153 | Referrals/Access: (251) 450-2211

MR#: | | | | | | EP: | | Date: | | - | | - | | | |
M M D D Y Y Y Y

ALTAPOINTE HEALTH
STATEMENT OF UNDERSTANDING AND CONSENTS

PATIENT NAME: ____

Review and initial each applicable area:

All Programs

_______ **Treatment/ Psychiatric Care**: I hereby authorize AltaPointe to provide me with treatment services, and if it is my child or ward, I hereby give consent for treatment:
Services may include the prescription of psychoactive medications and the administration of those medications by approved program staff. Emergency medications may be given to the patient (by mouth or injection) to prevent harm to themselves or others.
Children and adolescent inpatient patients will receive educational services on site as appropriate. Classrooms may consist of students receiving special and/or regular educational services. Due to our emphasis on treatment of emotional and behavioral difficulties patients will not be eligible to receive the same number of credits as they would on a public-school campus.

_______ **Consent for Follow-up contact:** I consent to AltaPointe staff members contacting ____**myself** ____**other contact** by letter, questionnaire, or telephone for establishing my current condition. I understand this information will be held in confidence and will not be disclosed without my written consent. I further understand this consent for follow-up will remain valid for a period of **ONE** year following my discharge from the program. I understand that I may revoke this consent at any time in writing. □ **I do not want to be contacted**.
Name: _________________________Address: ____ Phone#: _______________________

_______ **Health Information Exchange (HIE):** AltaPointe participates in a HIE called Care Quality and other designated HIEs. I understand that any physician or hospital that participates in the HIE either directly or indirectly may request for the purpose of my continuity of care the following limited set of records regarding my care: Allergies, Demographics, Labs, Immunizations Medications, and Problem Lists. You may choose to Opt-Out of allowing your health information to be shared through the HIE by requesting an Opt-out form.
All other releases will follow the practices explained in your Notice of Privacy Practices.

_______ **Payment Agreement:** For and in consideration of services rendered by AltaPointe, the patient (responsible person) hereby agrees to and guarantees payment of all AltaPointe charges incurred for the account of the patient from the date of admission until discharge. I understand that if an agency or company is responsible for payment of services, that agency or company will have the right to review the services I receive from AltaPointe. If the Probate Court placed me at AltaPointe, I understand that my insurance along with contract fees will be used to pay for services rendered while I am receiving services at AltaPointe.

I also understand that that I may be charged a fee or co-payment for services and that it is expected, if I am responsible for the payment of these services, to pay for them as they are received. I further understand I should contact AltaPointe if there are any changes to my insurance. A no-show fee may be charged if applicable.

Methods of Payment – Our office accepts the following payment methods: Cash, Personal Check, Credit Cards, and Money Orders.
There will be a $25.00 NSF charge for all returned checks.

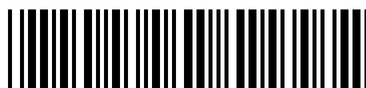
_______ **Fee Schedule:** I understand that I am responsible for payment for services rendered by AltaPointe Health, Inc. at its standard rates provided to me on the fee schedule.

_______ **Self-Pay –** I agree to pay AltaPointe in full for services rendered.

_______ **Medicaid:** Patient certifies that the information given in applying for payment under Title XIX (19) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the respective State Medicaid Agency or its intermediaries or insurance carries any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

N/A___ **Medicare:** Patient certifies that the information given in applying for payment under Title XVIII (18) of the Social Security Act is correct. Patient authorizes any holder of medical or other information about the patient to release to the Social Security Administration or its intermediaries or insurance carries any information needed for this or a related medical claim. Patient requests that payment of authorized benefits be made on his/her behalf.

_______ **Assignment of Insurance Benefits and Agreement to Pay Any Balance**: Patient (responsible party) irrevocably assigns and transfers to AltaPointe all right, title and interest to medical reimbursement benefits under any and all applicable medical insurance policies covering patient, for the payment of treatment and medical care being provided. Patient (responsible party) authorizes payment directly to AltaPointe Health of said medical reimbursement benefits. Patient (responsible party) is responsible for and co-payments, co-insurance, deductibles, and/or other amounts specified by my insurance. In the event the said medical insurance coverage is not sufficient to satisfy the AltaPointe charge in full, patient (responsible party) acknowledges that the resulting balance is not covered by this assignment and agrees to be fully responsible for the payment. I understand that my agreement with my insurance carrier is a private one, and that AltaPointe does not routinely research why my insurance carrier has not paid or why it paid less than anticipated for care.



MR#: [ ] EP: [ ] Date: MM - DD - YYYY

AltaPointe Health Statement of Understanding and Consents pg. 2

_______ **No Surprise Billing**: I have been informed of my right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees. The estimate is based on information known at the time the estimate was created and should complications or special circumstances occur, I could be charged more. If I am charged more, I have the right to dispute.

_______ **Integrated Healthcare Pharmacy Services**: As a patient at AltaPointe Health my prescriptions may, but are not required, to be filled at the Integrated Healthcare Pharmacy located at Gordon Smith Drive. AltaPointe Health has an ownership interest in Integrated Healthcare Pharmacy and offers the on-site pharmacy services for the convenience of the patient. It is the patient's decision as to where he/she chooses to fill their prescription.

_______ **Consent for Residents, Interns, and Medical and Nursing Students to Participate in my Treatment**: I am aware that, residents, interns, medical and nursing students, could be present for educational purposes. I understand that in the educational process they may observe or participate in my or my child's treatment and/or review my or my child's medical record.

_______ **Family Involvement**: Family involvement is an integral part of treatment especially when treating children and adolescents. I agree to make every reasonable effort to assist my or my child's therapist in scheduling a convenient time for this family therapy session. I do understand that failure to meet this requirement can result in denials of insurance payment related to non-compliance with treatment.

_______ **Responsibility for Destruction of Property**: The undersigned understands that patients are responsible for any damage to or destruction of AltaPointe property, or property belonging to others which may be located at AltaPointe. The undersigned and/or legal guardian agree to accept liability of and reimburse AltaPointe or other owners of property which the patient may damage or destroy.

_______ **Confidentiality of Information and Group Participation**: I understand that any information which is disclosed to me while I am a patient at this facility is confidential and that this information is protected by Federal law. I understand that this means that I will respect the rights of other participants by not talking with others outside the facility about what is said in treatment groups.

_______ **Patient Rights Statement**: I understand that AltaPointe subscribes to a Patient Rights Statement, which has been made available to me. I have had the opportunity to have the Patient Rights Statement explained to me.

_______ **Grievance Process**: I have been furnished with a copy of the Grievance process and had it explained to me.

_______ **Procedure to Review Records**: I have been furnished with a copy of the Procedure to Review my health record and had it explained to me.

_______ **Notice of Privacy Practices**: I have been furnished a copy of the Notice of Privacy Practices and have had it explained to me. I understand that the information concerning the treatment of ______________________________ will be held in confidence by the AltaPointe staff unless I give specific written consent for the release of information. In case of emergency AltaPointe is authorized to request or release that information which is essential to handle the emergency.

Also, AltaPointe staff will not release any information except as required by law or Court Order under compelling disclosure, or in a situation deemed potentially life-threatening, and in the following instances: Suspected Child Abuse, threats of physical harm to self and/or others, espionage, or sabotage.

The confidentiality of your participation may also be protected by federal and state laws and regulations. The violation of federal requirements is a crime, and suspected violations may be reported. Federal regulations do not protect from disclosure of information related to a patient's commission of a crime against AltaPointe property or personnel, or reports under state law of suspected child abuse or neglect (See 42 U.S.C. 290 ee 3 for federal laws 42 CFR Part 2 for federal regulations).
Please refer to the Health Information Exchange section of this document for HIE information.

_______ **Special Equipment**: I understand that special equipment, in the form of cameras, may be utilized at the facility for the safety of the patients.

_______ **Rehabilitation Act:** It is the policy of AltaPointe, in compliance with Section 504 of the Rehabilitation Act of l973, to afford qualified handicapped persons an opportunity to receive benefits or services that are equal to that offered non-handicapped persons. Any person who feels he/she has not received treatment in accordance with this policy may submit a compliant with the Patient Relations Department, AltaPointe Health, 5750-A Southland Drive., Mobile, Al. 36693.

_______ **Consent to Photographs**: I consent to have my photograph taken by the staff at AltaPointe as part of the admission process. I understand that this photograph will be placed in my individual medical record in keeping with this facility's system of patient identification and will be used for identification purposes only when necessary, during the course of my treatment.

_______ **Consent to Search**: I do hereby give my willing and informed consent to AltaPointe to search my personal belongings in my presence. **This consent is given to ensure that neither I nor anyone else in this facility has any prohibited items (dangerous objects, medications, contraband, or any other prohibited items**). I do understand that this search would also be performed in the event of my leaving the facility by the appropriate clinical staff member as AltaPointe deems necessary. I do also understand that this search is to include socks and underwear.

_______ **Responsibility for Personal Articles**: Patient (responsible person) acknowledges and agrees that AltaPointe does not assume responsibility for any personal possessions. Patient and/or legal guardian acknowledges and agrees to accept responsibility for any personal possessions. Patient acknowledges and agrees to accept responsibility for clothing and/or personal effects including dentures, eyeglasses, hearing devices, etc.

MR#: ______ EP: ____ Date: __ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

N/A _______ **Psychiatric Advance Directives:** ***(All Adult Programs)*** ___ I have a psychiatric advance directive and have provided a copy to AltaPointe. ___ I do not have a psychiatric advance directive and have been provided information by AltaPointe.

N/A _______ **Infection Prevention and Control Training:** I have received training on Infection Prevention and Control and had an opportunity to ask questions.

Children's Outpatient Programs

N/A _______ **Children's Outpatient Program Admission Agreement**: I have been furnished with a copy of the admission agreement and it has been explained to me.

Residential / Hospital Program

_______ **Seclusion & Restraint: The Last Resort**: I understand that AltaPointe's policy is to use Seclusion and Restraint only as a last resort. I have been given a copy of their policy and had the opportunity to ask questions. Physical restraint and/or seclusion may be used only in an emergency to protect the patient or others from imminent risk of harming self or others. This procedure has been explained to me. I understand that this is not used as punishment, but only as an emergency procedure. I understand that an attempt will be made to contact:

Name ____ Relationship: _____________________________

Phone Number: _________________________________.

N/A _______ **Consent for Participating in and Transport to Off-Ground Activities and therapies**: I give permission for me or my child to participate in off-ground activities such as movie, skating, museums, bowling, plays, etc., as approved by the attending physician. I understand that AltaPointe will provide reasonable supervision and will take reasonable precautions to provide for the safety and well-being of me and/or my child.

N/A _______ **Adult Residential Services and Transitional Age Residential Financial/Medical/Dental Responsibility Agreement:** As a resident of a residential care home, I understand that (1) I am charged up to 75% of my monthly income or up to $900 for room and board. (2) My room, board charges may be changed if my income changes. I am responsible for up to 75% of all my income for room and board for those months for which I am eligible. (3) I will reimburse the program for all personal expenses incurred while a resident at AltaPointe Health to include, but is not limited to, any property damage personally created. (4) I understand that AltaPointe provides no routine medical and dental care. The provision of payment for routine and major medical costs must be made prior to admission through patient resources, acceptable third party, or warranty by the sponsoring agent. I understand that I will be responsible for all my medical and dental care. If my relative/guardian/sponsor accepts responsibility for my medical and dental care, the signature is affixed below.

_______ **Child/Adolescent 24 Hour Care Program Elopement Report Permission**: I hereby give my permission as parent/legal guardian for the staff at AltaPointe to notify local law enforcement (police and/or sheriff's departments) of my child's full identity in the event of his/her unauthorized elopement from AltaPointe and/or the grounds. Identifying information may include name, birthdate, name(s) of parent(s), home address, and any other identifying information deemed potentially helpful in such a report.

_______ **Emergency Medical/Surgical Services**: I authorize and give my consent to AltaPointe staff to seek and obtain emergency medical/surgical treatment or dental treatment services as needed.

N/A _______ **Medical Advance Directives:** ___I have a medical advance directive and have provided a copy to AltaPointe. ___ I do not have a medical advance directive and have been provided information by AltaPointe.

_______ **Consent for Sex education**: State and National Guidelines for child/adolescent treatment facilities require that the patients be offered the chance to participate in sex education classes. AltaPointe will offer these classes on an informational level to those patients who are of age to make their own informed decision or whose parents/guardians wish to have them enrolled. I give consent for my child to participate in informational sex education classes.

_______ **Consent to Attend Church-Related Activities**: I agree or give permission for my child to attend church-related activities while a patient at AltaPointe. **(24-hour care programs)**

____

Print Patient's Name | Patient's Signature | Date

____ ____

Parent/Legal Guardian Signature | Date | Witness Signature/Credentials | Date

____

Witness Signature/Credentials (**required when signed with a mark**)

If patient signature is not present mark reason:

__________ Patient Unable to Sign

__________ Patient refused to Sign (Show multiple attempts)

Date: ____________________

Date: ____________________

Date: ____________________

Date: ____________________

Date: ____________________

MR#: [| | | | |] EP: [|] Date: [|] – [|] – [| | |]
M M D D Y Y Y Y

ALTAPOINTE HEALTH
INFORMED CONSENT FOR PSYCHIATRIC TELEHEALTH SERVICES

Patient Name: ____

Healthcare Practitioner: AltaPointe Health Credentialed Provider

Introduction

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient health information for the purpose of improving patient care. **This consent is valid for twelve months.** The information obtained may be used for diagnosis, therapy, follow-up, referral, and/or consultation, and may include one or both of the following:

- Live two-way audio and video
- Output data from medical devices and sound and video files

The interactive tele-video equipment and telecommunication lines used are HIPAA approved for patient security and privacy.

Expected Benefits

- Improved access to psychiatric care by enabling a patient to have a session with a psychiatrist while remaining at a remote site,
- More efficient medical evaluation and management.

Possible Risks

There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment,
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information.

By signing this form, I understand the following:

1. The laws that protect privacy and the confidentiality of psychiatric information also apply to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to other entities without my written or verbal consent.
2. I have the right to withhold or withdraw my consent (either written or verbally) to the use of telehealth in the course of my care at any time.
3. I understand that the health care provider is off site at a remote location.
4. I understand that none of the teleconference will be recorded or photographed.
5. I understand that in the event of technical difficulties an employee of the IT department, as well as additional staff, may be present during my session.
6. I may have to travel to see a health care practitioner in-person if I decline the telemedicine service.
7. If I decline the telemedicine services, the other options/alternatives available for me, including in person services, are as follows:____
8. The information from the telehealth service (images that can be identified as mine or other medical information from the telehealth service) cannot be released to researchers or anyone else without my **additional** written consent.
9. I will be informed of all people who will be present at all sites during my telemedicine service.
10. I may exclude anyone from any site during my telehealth service.
11. I may see an appropriately trained staff person, or employee, in-person, immediately after the telemedicine service if an urgent need arises. **OR,** I will be told ahead of time that this is not available.
12. I may contact the healthcare provider at phone number __________________________ for any questions I have related to medical services received through a telemedicine provider/site.

I understand that this consent will expire on _______________ (Twelve months from the signature date) **or** at the time of my discharge from this program, whichever comes first.

I have read this document carefully, and my questions have been answered to my satisfaction.

Printed Name of Patient: ____

Signature of Patient: ____ Date: _________________________

OR Signature of Parent or Legal Representative: ____ Date: _________________________

Signature of Witness & Credentials/ Title Obtaining Telemedicine Consent: _______________________________ Date: _____________________

BC 01023

Revised 11/30/2022

01023

MR#: [| | | | |] EP: [|] Date: [|] – [|] – [| | |]
M M D D Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION

I, ______________________________________ hereby consent to the verbal/ email exchange of information between
(Print patient name)

AltaPointe Health and: ____
(Guardian Name, Email Address, and Phone Number which information will be discussed with)

regarding Treatment, Medication, Diagnosis, and Discharge
(Information that will be discussed)

For admission of ______________________________________ and for the following purpose:
(Date of admission)

- ☐ Facilitate Evaluation and Treatment
- ☐ Participate in treatment
- ☐ Other

  Specify: ____

I understand that this consent will expire on _______________ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

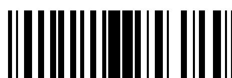
____ ____________________
Patient Signature Date

____ ____________________
Guardian/ Legal Representative Signature Date

____ ____________________
Witness Signature Date

____ ____________________
Witness Signature (if appropriate) Date

Revised: 11/30/2022
BC 01004 - ACG



MR#: [ ][ ][ ][ ][ ][ ] EP: [ ][ ] Date: [ ][ ] – [ ][ ] – [ ][ ][ ][ ]
M M D D Y Y Y Y

ALTAPOINTE HEALTH

INFORMED CONSENT FOR VERBAL / EMAIL EXCHANGE OF INFORMATION

I, ______________________________________ hereby consent to the verbal/ email exchange of information between
(Print patient name)

AltaPointe Health and: ____
(School Name/ Contact Person or Email Address which information will be discussed with)

regarding Treatment, Medication, and School Behavior
(Information that will be discussed)

For admission of ______________________________________ and for the following purpose:
(Date of admission)

- ☐ Facilitate Evaluation and Treatment
- ☐ Participate in treatment
- ☐ Other
  Specify: ____

I understand that this consent will expire on _______________ (Two year from the signature date) **or** at the time of my discharge from this program, whichever comes first. I understand that I may revoke this consent at anytime. The revocation may be given *verbally or in writing*, and it will not apply to information that was discussed prior to my revocation of this consent.

I have been informed that copies of my medical record can only be released by my signing an authorization giving my permission to do so.

____ ____________________
Patient Signature Date

____ ____________________
Guardian/ Legal Representative Signature Date

____ ____________________
Witness Signature Date

____ ____________________
Witness Signature (if appropriate) Date

Revised: 11/30/2022
BC 01004- ACS

MR#: ______ EP: ______ Date: __ __ - __ __ - __ __ __ __
M M D D Y Y Y Y

ALTA POINTE HEALTH
PSYCHOTROPIC MEDICATION CONSENT FORM

Patient Name: ____

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: ____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

______________________________	______________________________
Patient's Signature — Date	Guardian/Legal Rep. Signature — Date
Witness Signature — Date	Witness Signature (for use only if patient signs with a mark)

****

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: ____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

______________________________	______________________________
Patient's Signature — Date	Guardian/Legal Rep. Signature — Date
Witness Signature — Date	Witness Signature (for use only if patient signs with a mark)

****

I hereby acknowledge that I have received verbal and/or written educational material from my Physician/Nurse regarding the benefits, risks, and alternatives to treatment with: ____.

I have had the opportunity to ask questions, and I fully understand the information presented. I consent to take the medication (s) and realize that I may withdraw my consent at any time, in writing.

Do not sign this consent if you have not received verbal and/or written information and educational material regarding the medication you will be taking or if you have further unanswered questions.

______________________________	______________________________
Patient's Signature — Date	Guardian/Legal Rep. Signature — Date
Witness Signature — Date	Witness Signature (for use only if patient signs with a mark)

MR#: [| | | | |] EP: [|] Date: [|] – [|] – [| | |]
M M D D Y Y Y Y

CONSENT FOR PET THERAPY

I, ____, give consent for
(Guardian/ Legal Representative Name)

____, to participate in the Pet
(Patient Name)

Therapy program at ____________________________________and verify that he/she does not

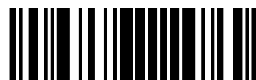
have any pet allergies.

____ ________________________
Patient Signature Date

____ ________________________
Guardian/ Legal Representative Signature Date

____ ________________________
Witness Signature Date

10/21/13 Revised 11/30/2022
BC 92077


92077