Patient Information Sheet

DATE: _____

PATIENT'S NAME: _____ DOB: _____Age: _____

SSN: _____ Marital Status: ( ) Married ( ) Single ( ) Divorced ( ) Other

PATIENT'S HOME ADDRESS: _____

CITY: _____ STATE: _____ZIP: _____
HOME PHONE: _____ WORK #: _____CELL: _____ OKAY TO LEAVE DETAILED MESSAGE AT: ( ) HOME ( ) WORK ( ) CELL

EMERGENCY CONTACT: _____RELATION: _____ PH: _____

PARENT OR GUARDIAN INFORMATION (RESPONSIBLE PARTY IF PATIENT IS UNDER 18):

PARENT/GAURDIAN: _____DOB:_____ SSN:___

_____ RELATIONSHIP TO PATIENT: _____

ADDRESS: _____ CITY, STATE, ZIP: _____

PRIMARY INSURANCE:
PRIMARY CONTRACT NUMBER: _____GROUP NUMBER: _____

NAME OF INSURANCE: _____INSURANCE PH #: _____

POLICY HOLDER NAME: _____ DOB: _____

SSN#: _____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

SECONDARY INSURANCE INFORMATION:

NAME OF INSURANCE: _____INSURANCE PH #: _____

POLICY HOLDER NAME: _____ DOB: _____

SSN#: _____ RELATIONSHIP TO PATIENT:_____

POLICY HOLDER ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

**** CANCELLATIONS MUST BE MADE NO LATER THAN 24 HOURS IN ADVANCE OF ANY SCHEDULED APPOINTMENT. SAME DAY CANCELLATIONS AND NO SHOWS WILL BE CHARGED A $50.00 FEE. ****

Adult Questionnaire

Name: _____ DOB: _____ Age: _____

Why are you seeking help?

When did the difficulty begin?

What makes it worse?

Does anything make it better?

What evaluations and/or treatment have you had in the past?

Please list medications used and results:

Past and current Therapist/Psychiatrist (Please include the year. This doesn't have to be completely accurate):

Family history (include name, mental health history and any medical problems):

Biological Father:

Education and Occupation:

Paternal family, members with mental health or substance abuse problems:

Suicide Attempts?

Biological Mother:

Education and Occupation

Maternal family members with mental health or substance abuse problems:

Suicide Attempts?

Current Household:

Adult members currently living with you:

Children (list names and ages and how they are doing)

Name	Age	School Performance	Mental health history

Your education and occupation:

Your developmental History:

Born and raised:

You parents were: Married Divorced (cir)

How many brothers and sisters? _____ You were the oldest, 2nd, 3rd, 4th,

Any History of physical or sexual abuse? YES NO

Any legal problems?

Any financial problems?

Medical History:

Current Physical/ last appointment:

Current problems and medication treatments:

Allergies (Please include environmental and medication allergies):

Please use this Space to tell me anything you think would be helpful for me to know.

HIPAA OMNIBUS RULES
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WIILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT INFORMATION BE SENT TO OTHER ATTENDING DOCTOR OR FACILITY IN THE FUTURE.

_____ _____

Printed name Signature Date

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE THIS OFFICE TO CONTACT ME VIA CELL, HOME OR WORK PHONE, EMAIL MESSAGE OR U.S. MAIL TO RELAY TREATMENT INFORMATION, BILLING INFORMATION OR INFORMATION ABOUT MY HEALTH. INTIAL: ____

_____

IF YOU PREFER THAT WE DO NOT CONTACT YOU, PLEASE OPT OUT BELOW: ( ) Cell Phone/ Text ( ) Work Phone ( ) Home Phone ( ) Email Message ( ) U.S. Mail ( ) Opt out all of the above

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. If we receive any remuneration, we, under current HIPAA Omnibus Rule, will provide you with this information and obtain your consent first.

The privacy of your health information is important to the pratctioners at 1643 Slaughter Rd, Madison, AL. We will maintain the privacy of your health information. We consult with other therapists within this facility as well as ancillary staff, in order to provide you with optimum treatment plans, handle any crisis situations that are beyond the normal business day, as well as facilitate your appointments and insurance filing and payment. Each member of this treatment team is bound by a code of ethics within their individual licensure or their employment contract. Please feel free to discuss this with your therapist if you have any questions or concerns.

I understand and agree to the privacy practices implemented by Dr. Swartz as stated above.

_____ _____

Signature Date

_____

Printed Name

Office Use Only: As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

_____It was emergency treatment

_____ I could not communicate with the patient

_____The patient refused to sign

_____The patient was unable to sign because _____

_____ _____

Signature of Privacy Officer Date

Received By: _____ **Provider: Daniel Swartz, MD**

Please read carefully the following and initial

Filing your insurance is a courtesy we provide for you. Since your insurance policy is a contract between you and your insurance company, the Guarantor/Client/Guardian is still responsible for co-pays, unpaid balances, or charges that are not covered by the insurance carrier. Initial here: _____

FINANCIAL AGREEMENT: I hereby assume full responsibility for all charges incurred for professional services rendered by my provider, unless the services are deemed "paid in full" as a result of a contractual agreement between my provider and my insurer. Payment is due at the time of service. Your practitioner uses Holloway Credit Services for outstanding bills of 6 months or greater. Initial here: ____

GROUP & INDIVIDUAL INSURANCE, ASSIGNMENT OF BENEFITS: I authorize my health insurance benefit plan to pay directly to my practitioner at 1643 Slaughter Rd, Madison AL 35758 the medical/psychiatric bee fits, if any, otherwise payable to me for their services as described on attached claim but not to exceed the charges for those services. I understand I am financially responsible for charges not covered by this agreement. Initial here: ._____

MEDICARE, CLAIM AUTHORIZATION AND PAYMENT REQUEST: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. Initial here: _____

AUTHORIZATION FOR RELEASE OF INFORMATION: I hereby authorize my practitioner at 1643 Slaughter Rd,Madison AL 35758 to release any medical, psychiatric, infectious disease or drug and/or alcohol related information to my referring physician, other healthcare providers within my provider and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client I further authorize the release of information to insurance company with whom I have medical benefits for the purpose of filing a medical claim. I acknowledge that this authorization is valid until such time as all medical bills related to my treatment have been paid. I further understand that I can withdraw this consent for release of information at any time prior to this expiration date. Initial here: _____

Cancellation and Missed Appointment Policy: Scheduled appointment times are reserved especially for you. If an appointment is missed or cancelled with less than 24 hours notice, you may be billed for half the missed or cancelled appointment. Your insurance company cannot be billed for fees associated with missed or cancelled appointments. We provide appointment cards for your convenience, but are not responsible for reaching you to remind you of your scheduled appointment. If you come in on a cancellation call basis, your original appointment is not cancelled unless you expressly request such. Initial here:_____

Consent for Treatment: I authorize and request my practitioner to carry out psychiatric exams, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my practitioner can make no guarantees about the outcome of my treatment. Further, the psychotherapeutlc process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be worked on between my practitioner and me. Initial here:_____

Telephone consultations: You may be charged for telephone consultations with your provider in excess of 5 minutes, or any calls placed after hours. Policies regarding phone contact and after hours emergency contact are unique to your provider and should be reviewed with him/her. Your insurance company will likely not cover charges for extended phone calls. Initial here: _____

Receipt of Privacy Practices: My Initials below indicates that I have had an opportunity to review a copy of the Privacy Practices of my provider and, that I have been offered a paper copy for my further review outside the clinic upon my request. I am also aware that I can request a further copy for clarification of the Privacy Practices at any time in the future. (Initial one): _____Copy Received _____Copy Declined

_____

Printed name of Patient/Parent/Guardian of Minor Signature Date

Please Initial you understand the following office policies.

APPOINTMENTS: (Please initial)

_____Patients 18 years of age and older are expected to handle their own appointments. Family members cannot make appointments for adults.
_____Cancellations must be made by the patient or custodian 24 hours in advance to avoid a charge. We can't accept cancellations made by relatives or non-custodians. If you fail to show or cancel within 24 hours of your appointment, you will be charged $50. Insurance companies will not reimburse patients for charges concerning late cancellations or missed visits. Call promptly if you need to reschedule an appointment. Set appointments can be rescheduled a maximum of two times. After two consecutive no-shows or three cancellations, the patient may be discharged.

TELEPHONE CALLS:

_____Telephone calls between appointments are reserved for pressing medical/psychiatric issues. Calls are answered 8 to 5pm, Monday through Friday. The doctor can be reached by calling our office number. If your doctor is unavailable, please leave a message with the secretary or answering service. Your call shall be returned as soon as possible. All calls will be triaged by front desk personnel. Please note that there may be a fee for phone calls, and that most insurance companies do not reimburse for this service.

PRESCRIPTIONS:

_____Prescriptions will be written/sent electronically at each appointment and we will provide you with at least sufficient medication and refills to extend until our scheduled next appointment. It is very important that you follow the doctor's orders related to medications and follow up appointments. If you must call the office for refill authorization between appointments, fees will apply. Messages for refills can be left as directed by our front desk.
_____Keep all prescriptions of controlled medications (e.g., Ritalin, Adderall, Dexedrine, Ativan, Xanax, Klonopin) in a safe place. Lost or misplaced prescriptions will not be refilled. All prescriptions are contingent on attendance to follow-up appointments. Any tampering or alteration of prescriptions will result in immediate discharge of the clinic. Stolen controlled medication will only be replaced after completion of a lost medication report to be placed in your file.

FINANCIAL POLICY:

_____Full payment is due in full at the time of service unless you are covered by one of our contracted insurance carriers. Insurance co-payments, deductibles and non-covered expenses are due at check in for the appointment. Your billing receipt can be submitted to your insurance company for reimbursement directly to you. The specific amount your insurance company will reimburse varies depending upon your policy. Check with your insurance company to determine the nature of your coverage.
_____Bills for services are issued if an amount remains after insurance has paid. Charges for evaluation and/or therapy sessions, telephone consultation, record review, and preparation of reports will be indicated on your bill. Prescriptions refills, and preparation of reports are charged $25. Changes in medications will be $35 if requested over the phone.
_____All payments for services should be made directly to Daniel Swartz, MD, MS, LLC. There will be a $30 penalty charged for returned checks. We honor payment with VISA and Master Card.
_____Any account 120 days in arrears will be assigned to a collection agency or attorney. Failure to meet your financial obligations may result in termination of clinical services.

By signing below, you agree to follow the office policies as outlined above and understand that not following these policies may result in you being referred to another practitioner.

Patient Name Signature Date