Psychiatric Care and Research Center
New Patient Form

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Date: _____ **Appt. Date:** _____ **Appt. Time:** _____

Name: _____ **DOB:** _____

Address: _____

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

Patient SSN: _____ **Phone #:** _____

On Disability? ___Y / ___N **Sex: ___M / ___F** **Marital Status: ___D / ___M / ___S / ___W**

Pharmacy name and number: _____

Referral Source/Primary Care/Returning Patient:

Have you ever been treated by a Psychiatrist/Therapist? If so, who:

Presenting Problem/Diagnosis:

Current Medications:

Any past or current alcohol/substance abuse issues? ___Y / ___N

When and what was last used? _____

Would you be interested in participating in a research study? ___Y / ___N

May we contact you if a study becomes available? ___Y / ___N

Primary Insurance Policy Holder: ___Self / ___Spouse / ___Parent / ___Other

Policy Holder's Name _____

Policy Holder's Employer: _____

Policy Holder's SSN: _____ **Policy Holder's DOB:**_____

Insurance Group #: _____ **Insurance ID#:** _____

Patient must call to verify their mental health benefits and that the provider is in network

New patients are required to confirm two days prior to the appointment. If you do not, your appointment will be cancelled and you cannot reschedule.

For those without insurance, we offer clinical research trials at time or discounted rates of $180 for a new patient appointment and $75 for follow up visits (Physicians only).

Please Note: co-pays are due at time of the visit.

Confidentiality Statement

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in State and Federal regulations.

I have read and understand the above statement.

Patient Signature	Date
Guardian Signature (*if patient is under 18*)	Relationship to Patient

Consent for Treatment

I, _____, hereby give the Physicians or Therapists of Psychiatric Care and Research Center my consent for any necessary medical evaluation, treatment, and/or counseling.

I hereby authorize this office to release medical records pertaining to my condition to appropriate parties for the purpose of coordinating my medical care and/or obtaining insurance benefits.

Patient Signature	Date
Guardian Signature (*if patient is under 18*)	Relationship to Patient

Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Psychiatric Care and Research Center appreciates the confidence you have shown in choosing us to provide your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to Psychiatric Care and Research Center, for providing services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Psychiatric Care and Research Center, the full and entire amount of bill incurred by me or the above named patient; or, if applicable, any amount due after payment has been made by my insurance carrier.

Patient Signature: _____ **Date:** _____

Guarantor Signature: _____ **Date:** _____

(*if guarantor is not the patient*)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time the service is rendered for the patient to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature: _____ **Date:** _____

Consent for Treatment and Authorization to Release Information

I hereby authorize Psychiatric Care and Research Center, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures.

I further authorize Psychiatric Care and Research Center, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature: _____ **Date:** _____

Cancellation and No Show Policy

We understand there may be time when you miss an appointment due to emergencies or an illness. However, we urge you to call 24 hours prior to your appointment.

There is a charge of $60 for missed appointments.

I understand if I do not show up for two consecutive appointments, do not show up for any three appointments, or cancel any four appointments, I may be discharged from care.

Psychiatric Care and Research Center will notify you in writing, via mail, if you are discharged from care.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature: _____ **Date:** _____

Self-Payment

If you do not have health insurance, you will be responsible for services rendered here at Psychiatric Care and Research Center. I agree to pay Psychiatric Care and Research Center the full and entire amount of treatment given to me, or to the above named patient, each visit.

Patient/Guarantor Signature: _____ **Date:** _____