Psychiatric Care and Research Center New Patient Form

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DATE: _____ APPT DATE: _____ TIME: _____ 6WFU: _____

Name: _____ **DOB:** _____

Address: _____

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

Patient SS#: _____ **Phone #:** _____

On Disability? Y____ or N____ **Sex: M/ F** **Marital Status: D M S W**

Referral Source/Primary Care/Returning Patient: _____

_____

Ever been treated by a Psychiatrist/Therapist? If so, who: _____

_____

Presenting Problem/Diagnosis: _____

_____

Current Medications: _____

_____

_____

Any past or current alcohol/substance abuse issues? Y____ or N____

When and what was last used? _____

Primary Insurance Policy Holder (check one):

Self_____ Spouse_____ Parent _____ Other_____

Policy Holders Name (other than self): _____

Policy Holders Employer: _____

Policy Holders SS# _____Policy Holders DOB: _____

Insurance Group #_____Insurance ID#_____

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

Insurance: (ins. card required or submit)

NEW PATIENTS ARE REQUIRED TO CONFIRM TWO DAYS PRIOR TO THE APPOINTMENT IF YOU DO NOT YOUR APPT WILL BE CANCELLED AND YOU CANNOT RESCHEDULE, THANK YOU.

FAILURE TO CANCEL AN APPOINTMENT WITHOUT 24 (BUSINESS) HOURS NOTICE WILL RESULT IN A FEE OF $60.00 FOR BOTH DOCTORS AND THERAPISTS. A REMINDER CALL WILL BE PLACED TWO DAYS PRIOR TO THE APPOINTMENT. THIS IS A COURTESY ONLY, IT'S NOT A REASON FOR DISPUTING THE NO-SHOW POLICY.

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

Would you be interested in participating in a research study? Y____ N____

May we contact you if a study becomes available? Y ____ N ____

Please Note: COPAYS are due at time of the visit.

Statement of Confidentiality

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 Part2, 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

_____ _____

PARENT 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

_____ _____

PARENT SIGNATURE

RELATIONSHIP TO PATIENT

Psychiatric Care and Research Center
Statement of Patient Financial Responsibility

Patient Name: _____ **DOB:** _____

Psychiatric Care and Research Center appreciates the confidence you have shown in choosing us to provide for 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 patients 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 _____

Psychiatric Care and Research Center
Statement of Patient Financial Responsibility

Cancellation / No Show Policy

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

There is a charge of $60.00 for missed appointments.

I understand if I no show for two consecutive appointments, no show for three appointments or cancel for a total of 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-Pay

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 at each visit.

Patient/Guarantor Signature _____ Date _____