DRYDEN-EDWARDS PSYCHIATRIC SERVICES 9055 SHADY GROVE CT. G'BURG 20877

Patient Information

Last Name: First Name: MI:

Home Address: City: State: Zip:

Sex: Male Female Other DOB: Age: SS#:

Home Phone: Work Phone: Cell Phone:

Occupation: Employer:

Spouse/Parent Name: Spouse/Parent Occupation:

PCP: Phone: Who referred you here?

Emergency Contact Information

In Case of Emergency Please Notify? Phone: Relationship:

Insurance Information

Do you have health insurance? ☐Yes ☐No Company Name:

Insurance Company Address: Company Phone:

Primary Insured Name: Relationship to Patient:

Policy Number: Group Number:

Who is responsible for this bill?

Office Policies and Information

Payment is expected at the time of service. The patient is responsible to provide a referral if it is required by your insurance company. If a referral is not provided the patient will be responsible for the total fee incurred. The patient will be held responsible for fees incurred if the insurance card provided is not valid or accurate. Reminder calls are not guaranteed and are only done as a courtesy. The patient is responsible for remembering all scheduled appointments. **All appointments must be cancelled 48 hours in advance and messages can be left on our voicemail. Missed appointments and late cancellations are charged as FULL FEE.** Account balances must be paid within 30 days. Payments not made by your insurance company within 90 days from the date of service could be turned over to you for payment. Account discrepancies must be settled within 60 days. Our office does not guarantee the accuracy of your copayments or of the amount your insurance company will pay. We are not responsible if your insurance does not pay or if they pay incorrectly. Our office will charge for medical reports, medical forms, medication authorizations, extensive phone calls, family consultations, consultations with other physicians and therapists. There will be a charge of $25 for any returned checks. Interest will be charged at the rate of 1.5% per month (18% annually) for any balance more than 30 days old.

I acknowledge that I am fully responsible for payment of the total bill incurred and I will be responsible for paying costs of collection action and reasonable attorney's fees.

AUTHORIZATION: By signing below this is authorization for Roxanne Dryden-Edwards, M.D., P.A. to apply for benefits on my behalf and to receive direct payment for services rendered to me by this office under Medical Services of D. C., Medicare, or any private insurance company listed on this form. I further authorize the release of any necessary medical information for any claim to my insurance company, primary care physician or managed care network.

Signature of Patient or Responsible Party:

_____Date:_____

Patient Acknowledgement & Consent Form

Use & Disclosure of Protected Health Information

Dryden-Edwards Psychiatric Service's "Notice of Privacy Practices" provides information about how we may use and disclose your protected health information. An official notice is posted on the wall in our office, or you may request your own copy at the front desk. Please acknowledge that you have been made aware of these Privacy Practices by initialing below:

_____
Patient's Initials

Our Notice of Privacy Practices states that we reserve the right to change the terms described. Should this happen, a revised copy will be posted and a copy made available to you.

_____
Patient's Initials

You have the right to request restrictions on how your protected health information may be used or disclosed for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreement with you.

_____
Patient's Initials

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in trust on your prior consent.

I request that payment of authorized Medicare/Insurance carrier benefits be made on my behalf to Roxanne Dryden-Edwards, M.D., P.A. for any services furnished to me by my physician or supplier. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and it's agent and/or any other Insurance Carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plan(s) as required by my insurance carrier(s). All co-payments must be paid at the time of service in accordance with the contracted Insurance Carrier Agreements.

Patient Signature (parent can sign for minor) Date

STAFF USE ONLY: Patient Refused to sign

Staff Signature: Date