Empower *Psych*

PATIENT INFORMATION

Date:	Name:	
Address:		
DOB:	Phone: *(home)*	Phone: *(cell)*
SSN:	Email: *Email reminders for appointments.*	

Employer:	Occupation:
Employer Address:	Employer Phone:

INSURANCE INFORMATION

(Please provide your insurance card to the receptionist.)

Responsible Party *(If different than patient):*	DOB:
	SSN:
Address*:*	Phone:
Primary Insurance:	
Insured Name:	Relationship:
Policy Number:	Group Number:
Secondary Insurance:	
Insured Name:	Relationship:
Policy Number:	Group Number:

IN CASE OF EMERGENCY

Name:	Relationship:	Phone:

I agree to receive treatment from Empower Psych Centers. I understand that I can withdraw this consent to treatment at any given time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

The above information is true to the best of my knowledge. I will pay my insurance copayment and other fees each session and have my insurance filed for me. I authorize Empower Psych Centers to release any information required to process my claims and my insurance benefits be paid directly to the clinic. I understand that I am financially responsible for any balance and any unpaid balances are subject to collections.

Patient/Guardian Signature

Date

MEDICAL HISTORY

Reason for Appointment:

Primary Care Physician Name:
Phone Number:

Please list all allergies:

Mental Health Treatment History *(please list diagnosis, outpatient treatment and hospitalizations*):

Medical History *(please list all significant medical problems):*

Current Medications *(please include dose and prescriber):*

Please list the person(s), if any, whom we may inform about your general condition, diagnosis and treatment: *This can be revoked at any time in writing.*

I understand that it is my responsibility to update this information with my provider as necessary to avoid delays in my treatment.

Patient Signature

Date

2019 POLICIES AND PROCEDURES

Treatment Plan: My provider and I will develop a treatment plan at the time of my appointment. This includes referrals, medications and frequency of follow up appointments. If I fail to follow my treatment plan or miss follow up appointments I understand that my medications may not be refilled or continued at the discretion of my provider. *I will need to reevaluate my treatment plan with my provider at a scheduled appointment before medications will be refilled.* _____ (Initial)

Urine Specimens: I understand that I may be subjected to a random urine drug screen based on my provider's discretion. Changes to my treatment plan, including my prescribed medications, could incur based on failure to provide or results of specimen. _____ (Initial)

Prescription Refills: It is my responsibility to check with my preferred pharmacy to see if I have refills available on my prescriptions. I will request refills at the time of my appointment or by calling the office and leaving my refill request on option #1 *(refill voicemailbox).* I will *allow 48 hours for my refill request to be completed* and understand that unless there is an issue with my request I will not receive a return phone call. I am responsible for my medications and understand that under no circumstance will my prescription be refilled before the specified due date. _____ (Initial)

Prior Authorizations: If my medication requires a prior authorization from my insurance company, office staff will complete the necessary paperwork and submit. It may take up to 72 business hours for my insurance company to approve or deny the request. _____ (Initial)

Insurance: It is my responsibility to notify the clinic of any changes in my insurance coverage or demographic information. Changes to my account are needed as soon as possible so treatment is not delayed. _____ (Initial)

Billing: I understand that I am responsible for any charges related to my treatment. If I have a balance after my time of service, I will receive an invoice from MidWest Health Care, a billing company utilized by the clinic. If I receive a bill and have questions regarding my balance I will contact MidWest at 1-800-303-4263. If my account is past due I understand I will be sent to collections. _____ (Initial)

Form Completion & Record Requests: Any paperwork or medical records I request *(or third-party requests on my behalf with written release)* to be completed will be charged based on provider time involved, with a minimum fee of $25. This includes FMLA, Disability, Attorney Statements and record transfers to other providers. I am responsible for payment at the time of request. _____ (Initial)

Confidentiality: Any information I disclose to my provider during treatment will be held strictly confidential unless I give written permission to disclose. _____ (Initial)

After Hour Emergencies: If I am experiencing suicidal or homicidal thoughts, unexpected medication effects or unusual behavior, I will call 911 or go to the nearest emergency room immediately. For non-emergent questions or requests, I will leave a message on the clinic voicemail and will receive a call back during normal clinic hours. _____ (Initial)

_____ _____

Patient Signature Date

UPDATED 2019 --- APPOINTMENTS AND SCHEDULING

24 Hour Notice: If I am unable to attend a scheduled appointment, I will notify the office within 24 hours of my scheduled appointment. _____ (Initial)

Missed Appointments: If I miss my appointment without notice I will be charged a $100 no show fee, that will automatically be charged to my credit card on file. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly. _____ (Initial)

Termination of Care: I understand that my care may be terminated if I miss three appointments. _____ (Initial)

Credit Card Payment for Late Cancellation or No-Show Appointments:

Card Type: Visa: _____ MasterCard: _____ American Express: _____ Discover: _____

Name on Card: _____

Billing Zip Code: _____ Expiration Date: _____ CVV: _____

Signature of Card Holder: _____

_____ _____

Patient Signature Date