

PATIENT REGISTRATION

PATIENT INFORMATION

Name: _____

(Last)

(First)

(Middle Initial)

Preferred Name

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

Social Security #: _____ Sex: ☐ Male ☐ Female DOB: _____ Age: _____Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____MAY WE CONTACT YOU BY PHONE FOR APPOINTMENT REMINDERS: ☐ YES ☐ NO IF YES PREFERRED # ☐ H ☐ C ☐ WA COPY OF THE PSYCHIATRIC EVALUATION WILL BE SENT TO THE REFERRING PHYSICIAN/THERAPIST UNLESS CHECKED ☐ DON'T SEND

RESPONSIBLE PARTY INFORMATION (Person who is financially responsible for payment)

Name: _____ DOB: _____

Relationship to Patient: _____ SS #: _____

Mailing Address: _____

Phone: (H) _____ (C) _____ (W) _____

INSURANCE INFORMATION

Primary Insurance Company: _____ Phone #: _____

Name of Insured: _____ Relationship to Pt.: _____

Insured SS#: _____ Insured DOB: _____

Insured Mailing Address: _____

Effective Date: _____ Employer: _____

Policy #/ Member ID: _____ Group ID# _____

Secondary Insurance Company: _____ Phone #: _____

Insurance Address: _____

Name of Insured: _____ Relationship to Pt.: _____

Insured SS#: _____ Insured DOB: _____

Insured Mailing Address: _____

Effective Date: _____ Employer: _____

Policy #/ Member ID: _____ Group ID# _____

EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone : _____

PATIENT SIGNATURE: _____ DATE: _____

ACKNOWLEDGEMENTS AND CONSENT

_____ I voluntarily consent to receive treatment at Apex Psychiatry. I consent to administration and performance of treatment/diagnostic procedures/ laboratory tests as deemed medically necessary or advisable by my treating physician or their assigned designees.

_____ I understand and agree that I will participate in my treatment plan and my non-adherence to treatment recommendations may result in being terminated as a patient. I also understand that I may discontinue treatment or withdraw my consent to treatment at any time.

_____ I hereby acknowledge that I have received or been provided the opportunity to receive a copy of the HIPPA privacy practices and understand that any questions or complaints may be addressed to the Privacy Officer without penalty.

_____ I authorize my insurance plans to pay directly to Apex Psychiatry the amount due for services rendered to me or the patient covered under the insurance plan. I hereby assign, transfer and set over to Apex Psychiatry all of my rights, title and interest to my medical reimbursement benefits under my insurance plans.

_____ I consent to the release of any medical, mental health, or substance abuse information about the patient required by my insurance company, administrator, managed care company, or review agencies, their employees or agents for the purpose of processing insurance claims for services rendered.

_____ I agree to take full responsibility for the entire amount due for any and all services rendered that are not covered by my insurance carrier. I also acknowledge that I am personally responsible for any deductibles, copays, or any other balance not covered by my insurance carrier. I fully understand that I may not be able to schedule further appointments if my account becomes delinquent or my account is turned over to collections.

Patient Name: _____

Patient Signature: _____ Date: _____

(Guardian's signature if patient is under 18)

Witness: _____ Date: _____

CHILD AND ADOLESCENT CONSENT (IF APPLICABLE)

I certify that I am the ☐ parent, ☐ legal guardian and have legal custody of the above named patient. I hereby consent and give authorization to Apex Psychiatry for the patient to receive treatment. I will be solely responsible for the payment of the patient's treatment and services rendered at Apex Psychiatry. Apex Psychiatry assumes no responsibility for collecting payment from the other parent or responsible party with whom I may have financial arrangements or agreements of any form for the patient's medical care.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

Apex Psychiatry

Sunita Singh, M.D., P.A.

Patient History

Patient Name: _____ Referred By: _____ Date: _____

Chief Complaint: _____

Current Symptoms

Please review the following and check any symptoms that you have been recently experiencing:

<input type="checkbox"/> Depressed Mood	<input type="checkbox"/> Inflated Self Esteem/Grandiosity
<input type="checkbox"/> Sleep Problem	<input type="checkbox"/> Decrease Need For Sleep
<input type="checkbox"/> Change in Appetite	<input type="checkbox"/> Racing Thoughts
<input type="checkbox"/> Decrease Interest	<input type="checkbox"/> Pressure to Keep Talking
<input type="checkbox"/> Decrease Energy	<input type="checkbox"/> Spending Spree
<input type="checkbox"/> Difficulty in Concentration	<input type="checkbox"/> Distractibility
<input type="checkbox"/> Guilt	<input type="checkbox"/> Impulsive Behavior
<input type="checkbox"/> Irritability	<input type="checkbox"/> Trying to do Way Too Much
<input type="checkbox"/> Crying Spells	<input type="checkbox"/> See/Hear Things That May Not be Real
<input type="checkbox"/> Excessive Worrying	<input type="checkbox"/> Suspect/Believe Things That May Not be Real
<input type="checkbox"/> Often Tense/Keyed up	<input type="checkbox"/> Cannot Stop Repetitive Thoughts
<input type="checkbox"/> Panic Attack	<input type="checkbox"/> Cannot Stop Repetitive Behavior
<input type="checkbox"/> Intrusive/Recurrent Memory of Past Trauma	<input type="checkbox"/> Hyper Vigilant
<input type="checkbox"/> Other (Please explain)	

Stressors: _____

Past Psychiatric History

In-Patient Psychiatric Treatment: ☐ No ☐ Yes _____

Out-Patient Psychiatric Treatment: ☐ No ☐ Yes _____

Past Psychiatric Medication: ☐ No ☐ Yes _____

History of Suicide: ☐ No ☐ Yes _____

History of Violence: ☐ No ☐ Yes _____

Substance Abuse History

Average per Day/How long

Alcohol: ☐ No ☐ Yes _____

Tobacco: ☐ No ☐ Yes _____

Illicit Drugs: ☐ No ☐ Yes _____

Apex Psychiatry

Sunita Singh, M.D., P.A.

Patient Name: _____

Date: _____

Medical History

Primary Care Physician's Name: _____

Do you have any of the following medical problems?

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Allergies	<input type="checkbox"/> Migraine Headaches
<input type="checkbox"/> CHF	<input type="checkbox"/> Chronic Lung Disease	<input type="checkbox"/> Seizures
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Anemia	<input type="checkbox"/> Head Injury
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Stroke
<input type="checkbox"/> Stomach Ulcers	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Other Medical Problems: _____		

Past Surgical History: ☐ No ☐ Yes _____

Past Hospitalization: ☐ No ☐ Yes _____

Please list all current medications including over the counter and herbal medications:

Allergies: _____

Family History

Family Medical History: ☐ No ☐ Yes _____

Family Psychiatric History: ☐ No ☐ Yes _____

Social History

Developmental History/Issues: _____

Marital Status/Relationship: _____

Education: _____

Occupation: _____

Religious Affiliation: _____

Legal Issues: _____

Living in: _____ with _____

Patient/Parent/Guardian Signature: _____ Date: _____

Reviewed By: _____ Date: _____

PHARMACY INFORMATION

PLEASE PROVIDE THE FOLLOWING INFORMATION FOR E-PRESCRIBING TO YOUR PREFERRED PHARMACY

PATIENT NAME: _____

PREFERRED PHARMACY NAME: _____

PHARMACY ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHARMACY PHONE NUMBER: _____

PHARMACY FAX NUMBER: _____

Contract for Controlled Substance Prescriptions

I _____, hereby consent to the following:

PATIENT NAME (PLEASE PRINT)

- If the Controlled Substance prescription or medication is lost, misplaced, stolen, or if I use it up sooner than prescribed, I understand that it will not be replaced.
- While I am receiving controlled substance medications from Apex Psychiatry I will not request nor accept the same controlled substance medications from any other physician, or individual. Besides it being illegal to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital or previously discussed with my physician.
- Refills of controlled substance medications:
 - Will only be made during regular office hours, in person, over the phone, via pharmacy or during an office visit. Refills will not be responded to at night, on holidays, or weekends.
 - I will keep track of my medications and call at least 48 hours ahead if I need assistance with a controlled substance medication prescription.
 - Will not be made if I "run out early". I will not take more medication than prescribed unless I speak with my doctor first. If I overuse my medication I will go through withdrawal, which is severe and potentially fatal. It is caused by cessation of a controlled substance and symptoms of which include severe tremors, confusion or even seizures. If this happens I have been instructed to seek emergency help immediately.
- I will not take any "street drugs". I understand that taking any non-prescribed drugs, changing or stopping medications without discussing with my physician may result in discharge from Apex Psychiatry or reevaluation of my current treatment.
- I understand the importance of following my treatment plan as directed by my physician and agree:
 - To attend all appointments(Follow-Up and /or referrals)
 - To permit urine drug screening without prior notice
- I understand that if I violate any of the above conditions, my controlled substance prescriptions and/or treatments at Apex Psychiatry may be ended immediately. If the violation involves obtaining controlled substances from another individual, as described above, I may also be reported to my primary physician, local medical facilities and other authorities.
- I have been fully informed by my doctor that the medication could be habit forming and could potentially need higher doses to achieve the same result. This typically can occur after weeks to months. To stop medications, I must do so slowly under medical supervision or I may have withdrawal symptoms.

If patient or someone else takes more than the prescribed/recommended dose of a medicine, call 911, contact poison control or go to an emergency room immediately.

My signature below hereby indicates consent to treatment and understanding of the Controlled Substance Medication policies.

PATIENT/GUARDIAN/LEGAL REPRESENTATIVE SIGNATURE

DATE

SIGNATURE OF TREATING PHYSICIAN

DATE

OFFICE POLICIES AND PROCEDURES

- **Office Hours and Appointments:** Our office hours are Monday through Thursday 8 a.m. to 12 p.m., and 1 p.m. to 4 p.m., and Friday 8 a.m. to 12 p.m. Patients can schedule appointments by calling during regular office hours. If you cancel an appointment we require a 24 hours' notice. **You will be charged a \$50.00 fees for appointments missed or cancelled without a 24 hour notice and is payable prior to any future appointments.** These will not be billed to your insurance company and will be your responsibility. Multiple missed appointments may result in termination from our practice. Late arrivals may not be seen and may be asked to reschedule their appointment. Please be considerate to other patients' appointments and the physician's schedule. **You must present a valid Government issued photo identification and your insurance card prior to being seen at each appointment.**
- **Termination:** Threats or acts of physical harm to any employee of the practice or office property will result in immediate termination of treatment and notification of the proper authorities.
- **General:** At Apex Psychiatry we do not practice Forensic Psychiatry. We do not involve in worker's compensation cases, divorce/child custody cases, fit for duty, disability evaluations or forms or other legal matters including testimony or reports in civil matters. If you need such services you will need to be referred to another psychiatrist outside of our practice.
- **Phone calls and Emergencies:** We will take phone calls and messages during regular working hours. We will respond to your call no later than the next business day. If you leave a message after-hours we will respond to it the next business day. If you are having an emergency need and cannot wait for a return phone call, or you are in danger of harming yourself or others, please call 911 go to the nearest Hospital Emergency Room. Please note that we are not a 24-hour facility.
- **Prescriptions and Refills:** We require a 48-hour notice for prescription refills. You are responsible to ensure that you do not run out of your medications. Call your pharmacy to request prescription refills from our office. If you cancel or miss your appointment and require a prescription refill prior to your next scheduled appointment we will only issue a 2-week supply or enough medication to last you till your next appointment whichever is less. **Controlled or scheduled medications may not be replaced or filled early.**
- **Financial Policy:** Payment is due at the time of service. We accept cash, debit or credit card (Visa, MasterCard, and Discover). Patients are responsible for their co-payments, deductibles and any outstanding charges at the time of service. Any balance on an account that is greater than 30 days is considered past due. Balance of services that are delayed or denied by your insurance company will become your responsibility after 30 days. We do not guarantee that payment will be authorized for services and are not responsible to for any adverse payment decisions by your insurance company. **Please provide notification of any changes in your insurance coverage 48 hours in advance of your appointment or payment in full will be required.** We will collect delinquent accounts through a collection agency. In the event of account placement with a collection agency the applicable collection fees will be added to that account.
- **Cellular devices, Cameras, Camcorders or any other recording/photography devices are prohibited.**
- **Miscellaneous Charges:**
 1. Fees for copies of medical records are \$25.00 for the first 20 pages and \$0.50 for each page thereafter. It may take upto 15 business days to prepare medical records.
 2. Any letter or forms requested by the patient will be charged a preparation fees of \$50.00 and up. It's at your doctor discretion to complete it at or not , Prepayment is required for any paper work and may take 5-10 business day to complete.

I acknowledge that I have carefully read and understand the Office Policies and Procedures and accept all the terms as described above. I understand that Office Policies and Procedures may be amended or modified from time to time by the practice.

Patient Name (Please Print)

Date

Signature of Patient/Parent/Guardian

Relationship to Patient

Witness

Date