# PATIENT REGISTRATION

## PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) Preferred Name

Mailing Address: _____

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

Social Security #: _____ Sex: □ Male □ Female DOB: _____ Age: _____

Email: _____

Marital Status: □ Married □ Single □ Divorced □ Widowed □ Other _____

**MAY WE CONTACT YOU BY PHONE OR EMAIL FOR APPOINTMENT REMINDERS: □ YES □ NO, IF YES PREFERRED □ C □ EMAIL**

**A 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) _____

## 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# _____

## EMERGENCY CONTACT INFORMATION

Name: _____

Relationship: _____ Phone: _____

**PATIENT SIGNATURE**: _____ DATE: _____

## ACKNOWLEDGEMENTS AND CONSENT (Please initial & sign)

_____ 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 (please print): _____

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 (please print): _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____Date: _____

## OFFICE POLICIES AND PROCEDURES (Please initial & sign)

_____**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-hour notice. You will be charged a $50.00 fee 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, disability evaluations 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. 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 feels 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 up to **15 business days** to prepare medical records.
2. Any letter or forms (e.g.,FMLA) requested by the patient will be charged a preparation fees of **$50.00**.

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.

Parent/Guardian Name (please print): _____

Parent/Guardian Signature: _____ Date: _____

Witness: _____Date: _____

# CREDIT CARD AUTHORIZATION FORM

Please complete all fields if you wish to keep payment information on file with our office. You may cancel this authorization at any time by contacting us at Apex Psychiatry 214-383-5630. The authorization will remain in effect until cancelled.

**Credit Card Information**

Card Type: _____

Card Holder's Name (as shown on card): _____

Card Number: _____ CVV: _____

Expiration Date (mm/yy): _____

Cardholder ZIP Code (from credit card billing address): _____

Patient's Full Name: _____

Patient's Date of Birth: _____

I, _____, authorize Apex Psychiatry to charge my credit card for the above patient's appointments. I understand that my information will be saved to file for future transactions on my/patient's account. It is the responsibility of the signing cardholder to notify our office if there are any changes to the information provided above.

_____ _____

Customer Signature Date

**CONTRACT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS (please initial & sign)**

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

## PHARMACY

**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: _____