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 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: _____

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-hour notice. You will be charged a $100 fee for new patients or a $50.00 fee for establish 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**. A credit card is required to be kept on file and will be automatically charged for these missed appointments. (See Financial Policy below).** 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. **The credit card on file will be automatically charged for scheduled appointment copay, deductible, balance due and missed appointment fees. (See Office Hours and Appointments above) before the appointment. Please provide notification of any changes in your insurance coverage or credit card information 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 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 fee 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.

Patient/ Parent/Guardian Name (please print): _____

Patient/ Parent/Guardian 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)

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: _____

APEX PSYCHIATRY CONTROLLED SUBSTANCE POLICY (Please initial & sign)

I, (name) _____ (DOB) _____,
understand that my provider is prescribing a controlled substance medication as part of my treatment plan. This controlled substance policy is a tool for communication allowing us to work together in good faith. This requires cooperation, trust and mutual respect. If you cannot agree with the following terms, we will be unable to prescribe controlled medication.

_____1. I will take the medication exactly as prescribed and I will not change the medication dosage and/or frequency without the approval of my physician. I agree to not share my medication with anyone.

_____2. I will keep regularly scheduled appointments with my physician. If refills are needed between office visits, please call our staff at least 3 days before your medication runs out.

_____3. I understand that no early refills of medication will be authorized.

_____4. I understand that I will not be given a dosage that is higher than FDA guideline maximum recommended dosage. I understand if I am currently on a higher dosage than the FDA maximum recommended dosage, then my provider may decide to reduce the dosage or change the medication.

_____5. I will not accept or seek controlled substance medication from any other physician or health care provider outside of our practice while we are prescribing controlled medication. I understand that I must keep my provider informed of all medication that is prescribed to me outside of this practice.

_____6. I understand that office staff is not permitted to refill controlled medications without provider approval.

_____7. I understand that my controlled prescription will only be sent to one pharmacy and cannot be transferred or sent to multiple locations.

_____8. I understand that lost, stolen or misplace prescriptions or pills will not be replaced.

_____9. I agree that I will not use any illegal drug(s) while receiving care and medication from this practice.

_____10. I agree and understand that my physician reserves the right to obtain urine drug testing. The drug testing will be required at a minimum of the onset of the prescription and every 3-6 months. Initial prescriptions will not be sent to the pharmacy until drug screen is received. If I fail to obtain drug screen when asked or if the results are inconsistent, I may forfeit the right to continue receiving controlled medication.

_____11. I understand that I should not mix benzodiazepine (anti-anxiety) medications with alcohol and/or opiate (pain) medications. There is a major risk of decrease respiratory rate that can lead to death when mixing these medications with other substances.

IF YOU HAVE ANY QUESTIONS CONCERNING OUR MEDICATION AGREEMENT OR WE CAN ASSIST YOU IN ANY WAY, PLEASE FEEL FREE TO CALL ON OUR OFFICE STAFF.

I have read this agreement. I fully understand the consequences or violating this agreement may include cessation of therapy with controlled substances and/or discharge from this practice.

Print Name: _____ DOB: _____
Signature: _____ 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: _____