PsychiatrySOUTH

2018 Established Patient Update

Identifying Information

Last Name: _____ **Middle Initial:** ___ **First:** _____ **Suffix:**___

Date of Birth: ___/___/___ **Gender Identity:** _____ **Marital Status:** _____
Employer: _____ **Occupation:**_____

Sexual Orientation *(circle one)* : Heterosexual/Straight // Lesbian/Gay/Homosexual // Bisexual
Choose Not To Disclose

Preferred Language: _____ **Race:** _____ **Ethnic Group:** _____

Communication Info

Address: _____

Preferred Phone Number: (___) ____-_____ **Email:** _____@_____

Preferred Pharmacy Name & Phone Number: _____
We must have the Pharmacy Phone Number on file

Emergency Contact
Name:_____ **Relationship:** _____ **Phone Number:** _____

Spouse and/or Parent/Guardian Info *(if applicable)*
Name: _____ **DOB:** ___/___/___ **Phone Number:** (___) ____-_____
Relationship to Patient: _____ **Employer:** _____

Insurance Info: **Have there been any changes to your insurance? Yes or No**
If yes, please complete the info below. *Please note that failure to provide current, accurate info may result in self-responsibility for payment.*
Primary Ins Name: _____ **Subscriber/ID Number:** _____ **Group#:**____
Subscriber Name *(if not self)*: _____ **Relationship to Patient:** _____
DOB: ____/____/____ **SSN:** ____-____-_____ **Subscriber's Employer:** _____

Secondary Ins Name: _____ **Subscriber/ID Number:** _____ **Group#:**____
Subscriber Name *(if not self)*: _____ **Relationship to Patient:** _____
DOB: ____/____/____ **SSN:** ____-____-_____ **Subscriber's Employer:** _____

Printed Patient Name: _____ **Date:** _____/_____/_____

Signature of Patient or Patient Representative: _____
Printed Name of Responsible Party or Representative *(if not patient)*: _____

Office Personnel Use:

Received In-Office/Completed Date: _____/_____/_____ Initials: _____
Entered/Updated In System Date: _____/_____/_____ Initials: _____

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General Practice Policies

Appointment Policy

An appointment is considered a mutual commitment between you and your clincian, and is subject to personal accountability and responsibility in keeping and managing the appointment. A 24 (twenty-four) hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Appointments for which you arrive late will still end at the appointed time. We do not overbook or double book, so the session is your responsibility for managing. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping your appointment is ultimatley yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling (*if applicable*) of the appointment. ***Initials*** _____

Payment for Services

Psychiatry South will directly bill your insurance company following your service. Your co-payment and any deductibles and balances, which may apply, will be collected when you check-in. If we are not billing an insurance company for your service, the full payment is due at the time of service. Psychiatry South accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. If your contract requires a referral for care, it is your responsibility to acquire the referral. ***Initials*** _____

Confidentiality

The clinic operates in a "multi-disciplinary" way, meaning that the clinicians function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicide or homicide issues or child/elder abuse or neglect. You will complete a Release of Information that you can list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your account here at PSI.

Children (under the age of 17) have the right to confidential exchanges with clincians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians. Due to the charting nature of PSI and the clincial focus of our work with families (not legal), custody issues will not be addressed. Additionally, no court ordered evaluations will be performed. ***Initials*** _____

Treatment Issues

Our office staff will take messages during regular business hours. Please allow 48-72 (business) hours for a response as clincians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We are able to address routine concerns much more effectively than crisis concerns. If your concern involves a safety issue, please notify the front desk so that your clinican can be paged. If you have an after-hours concern, you may leave a message on our voicemail. If your need is emergent due to safety issues after-hours please call 911 or go to the nearest Emergency Department. ***Initials*** _____

Laboratory Policy

It may be medically necessary for your physician to request lab or radiologic tests in order to provide the best treatment possible. It is your responsibility, as our patient, to obtain the requested examinations. Our office will assist you as much as possible, but testing may require you to visit another facility or lab. If you do not obtain these tests within a reasonable time, your physician reserves the right to refuse to refill or prescribe further medications until tests are completed. Urine drug screens are performed on patients when necessary. All new patients and patients who are prescribed controlled medication will have an initial urine drug screen and will be subject to montly UDS after. Any charges that may result from the UDS will be the resposibility of the patient if not covered by the insurance company. ***Initials*** _____

Dismissal

If you are "dismissed" from the practice it means you can no longer schedule appointments, get medication refills or consider us to be your physician/therapist. You have to find a physician/therapist in another practice. Common Reasons for Dismissal: Failure to keep appointments, frequent no-shows; Noncompliance, which means you have failed to follow physician instructions about an important health issue; Abusive (verbal or physical) to staff; Failure to pay your bill. We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on this letter, we will assist you with care options. We will forward a copy of your medical record to your new physician when a release is received. ***Initials*** _____

Consent

I have read and understand these policies in their entirety and agree to abide by these terms. I am also aware that if I have questions about this document, I am encouraged to bring them to PSI's attention.

Please indicate your agreement to the terms of this policy by signing below: **Date:** _____/_____/_____

Printed Patient Name: _____ **Signature of Patient:** _____

Printed Name of Responsible Party (if not patient): _____ **Signature of Responsible Party:** _____

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Medical Informaton Release Form and Notice of HIPAA

Patient Name: _____ **Date of Birth:** _____/_____/_____

Release of Information:

_____ (Initials) Information is **not** to be released to anyone.

OR

_____ (Initials) I authorize the release of information including the diagnosis, records, examiniations rendered to me and claims (financial) informaiton.

Information May Be Released To:

_____ Spouse

Name of Spouse: _____

_____ Child(ren)

Name(s) of Child(ren): _____

_____(Other)

Name(s): _____

Messaging:

Messages may be left (*initial where appropriate*):

Cell _____ *(Initials)*
Home _____ *(Initials)*
Work _____ *(Initials)*

Pre-Recorded/Appointment Reminder calls, emails and/or text messages may be left on my contact numbers listed on demographic form.

_____***(Initials)***

Coordination of Care:

Please list the names and phone numbers of other physicians from whom you are receiving care.

Name: _____ Phone Number: (_____) _____-_____
Name: _____ Phone Number: (_____) _____-_____
Name: _____ Phone Number: (_____) _____-_____

Psychiatry South strives to provide accurate care and therefore requests permission to speak with any other physician(s) who may also be treating you. Please indicate, by signing below, that PSI has your permission to speak with the above referenced physicians to coordinate your care.

HIPAA:

I have received notice of Psychiatry South HIPAA Privacy Practices and understand the document completely. _____ ***(Initials)***

By signing below, I have read the above information and agree to all of the contents, inlcuding 'Coordination of Care' with my physicians.

Date: _____/_____/_____

Printed Patient Name: _____ Signature of Patient: _____

Printed Name of Responsible Party (*if not patient*): _____ Signature of Responsible Party: _____