PsychiatrySOUTH

New Patient/Client Registration Form

Last | Middle | First | Date of Birth: | Gender:

Social Security Number | Marital Status: (Single, Married, Divorced, Seprated, Widowed) | Address: *(Street number, name, city & zip)*

Home Number: | Cell Number: | Work Number:

Email Address: | Employer: | Occupation:

Primary Care Physician: | PCP Phone Number:

Referring Physician: | Phone Number:

Pharmacy Name: | Pharmacy Phone Number:

Identifying Information:

Preferred Language: | **Ethnic Group**: ◯ Hispanic or Latino ◯ Not Hispanic or Latino ◯ Unk or Decline

Race: ◯ Caucasion or White ◯ African American or Black ◯ Asian ◯ American Indian or Alaskan Native ◯ Native Hawaiian or Other Specific Island ◯ Other Race

Person Responsible for Payment:

Last | Middle | First | Relationship to Patient: | DOB:

Emergency Contact(s):

Name: | Phone:

Name: | Phone:

Insurance Information (Primary):

Are you using any type of EAP (*Employee Assistance Program*) options? ◯ or ◯ *If yes*, what company:

Insurer Name: | Subscriber ID:

Group Number: | *(If Applicable)* Authorization Number:

Subscriber Name (*If different from self*):

Subscriber Date of Birth: | Subscriber Social Security Number:

Subscriber's Employer: _____

Secondary Insurance:

Insurer Name: | Subscriber ID:

Group Number: | *(If Applicable)* Authorization Number:

Subscriber Name (If different from self):

Subscriber Date of Birth: ____/____/____ | Subscriber Social Security Number: ____-____-____

Subscriber's Employer:

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. ***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:
Initial only one in this box

_____ (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: _____

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No-Show/Missed Appointments and Late Cancellation Policy

It is your responsibility as our patient to attend all scheduled appointments. If, for some reason, you are unable to make your appointment, it is your responsibility to cancel the appointment with a member of our staff, 24 (twenty four) hours prior to the scheduled appointment time. If you miss or fail to cancel an appointment, you will be charged an initial fee of $ 75.00. Subsequent failures will result in full fee schedule charges ranging from $100-$210.00.

Habitual offenders, more than three missed appointments (late cancellation or no-show) will be subject to discharge from the clinic.

Insurance will not be billed for these charges and are the patients sole responsibility.

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:

MEDICATION REFILL POLICY

During the course of treatment at Psychiatry South, you may be prescribed medications. It is your responsibility, as the patient, to notify your physician if you need a refill at your scheduled appointment Failure to show or frequently canceling your appointments whereby your medications would be refilled, without rescheduling, is not being compliant with clinic policies and you could be subject to discharge from the clinic. *Please note that no refills will be called-in after-hours or on the weekends*. You must attend all scheduled appointments with your physician and not request medication refills when you have failed to follow- up appropriatley.

Controlled Substances *(including stimulant medications such as Concerta, Adderall, etc.)* will be issued by your clinician on a **month-to-month** basis. Because these medications are highly regulated, prescriptions must be picked up and appointments must be kept. Also, in the event that a prescription for a controlled substance, or the medication itself, is lost it will not be re-written. Patients are subject to random urine drug screening while being prescribed a controlled medication.

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:

Controlled Substance(s) Contract

Controlled substance medications *(i.e. benzodiazepines, opioids, amphetamines)* are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal government(s). As a patient of Psychiatry South, you agree and understand the following ***(initial each section)***:

_____**1)** I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen or if "I run out early," I understand this medication will not be replaced regardless of the circumstances.

_____**2)** Refills of controlled substance medications:

A: Will be made only during regular office hours Monday through Friday, in person, once a month, and during a scheduled office visit. Refills will not be made at night, weekends or on holidays.

B: Will not be made if "I lost my prescriptions," "ran out early," or "misplaced my medication." I am solely responsible for taking the medication as prescribed and for keeping track of the remaining.

_____**3)**I agree to comply with urine drug testing and pill counts at every appointment, thereby, documenting the proper use of any medications. If alcohol abuse is suspected, blood alcohol levels may be ordered.

_____**4)**I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated. If the violation involves obtaining these medications from another individual, or the concomitant use of non-prescription illicit (illegal) drugs, I may also be reported to other physicians, pharmacies, medical facilities, and the appropriate authorities.

_____**5)**I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, such as, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from Psychiatry South.

_____ **6)** I agree to keep my scheduled appointments, adhere to the payment policy outlined by the office and conduct myself in a courteous manner while in the office.

_____ **7)** I agree to not sell, share, or give any of medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.

_____**8)** I agree not to obtain medication from any doctors, pharmacies or other sources without telling my treating physician.

_____**9)** I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

_____**10)** I agree to abstain from alcohol, opioids, marijuana, cocaine and other addictive substances.

_____**11)** I agree to fill all of my controlled medications at an in-state (Alabama) pharmacy. I will list my pharmacy of choice below and understand that I must utilize this pharmacy. If at any time, I choose to change my pharmacy, I will notify Psychiatry South and complete this information again:

- Pharmacy Name: _____ Pharmacy Phone Number: _____

_____**12)** I understand that Psychiatry South utilizes the State of Alabama Prescription Drug Monitoring Database and will monitor my prescription history via this source.

I have been fully informed of the above treatment agreement points and have a full understanding of my duties as a patient of Psychiatry South in regard to the controlled substances my physician is prescribing.

Patient Signature: _____ **Date**: _____

Physician Signature: _____ **Date**: _____

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Informed Consent for Telehealth Services

Telehealth involves the use of electronic communications to enable the clinicians at Psychiatry South, Inc. to connect with individuals using interactive video and audio communications.

I understand that I have the following rights/responsibilities with respect to Telehealth:

1. ☐ The laws that protect the confidentiality of my personal information also apply to Telehealth. As such, I understand that the information disclosed by me during the course of my sessions is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to, reporting child, elder, and dependent adult abuse. I also understand that the dissemination of any personally identifiable images or information from the Telehealth interaction to other entities shall not occur without my consent.

2. ☐ I understand that I have the right to withhold or withdraw my consent to the use of Telehealth in the course of my care.

3. ☐ I understand that there are risks and consequences from Telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the clinician, that: the transmission of my personal information could be disrupted or distorted by technical failures, the transmission of my personal information could be interrupted by unauthorized persons, and/or the electronic storage of my personal information could be unintentionally lost or accessed by unauthorized persons. Psychiatry South utilizes secure, encrypted audio/ video transmission software to deliver Telehealth.

4. ☐ I understand that if my clinician believes I would be better served by another form of intervention (e.g., face-to-face services), I will be referred for in-person visits within the office. Alternatively, Psychiatry South will provide a mutual discharge and references for continued care.

5. ☐ I understand the alternatives to treatment through Telehealth as they have been explained to me, and in choosing to participate in Telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my clinician, I may be directed to "face-to-face" visits.

6. ☐ I understand that I may expect the anticipated benefits such as improved access to care and more efficient evaluation and management from the use of Telehealth in my care, but that no results can be guaranteed or assured.

7. ☐ I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my clinician in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the Telehealth service and thus will have the right to request the following: (1) omit specific details of my medical history that are personally sensitive to me, (2) ask non-clinical personnel to leave the Telehealth room, and/or (3) terminate the visit at any time.

8. ☐ I understand that I am responsible for my own environment and those present or within any distant whereby they could hear or interpret my session with my clinician. I understand I must secure a safe, quiet place of my own choosing to participate in Telehealth services.

9. ☐ By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based Telehealth services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area.

10. ☐ I understand that different states have different regulations for the use of Telehealth. I understand I must inform the clinician and/or office staff if I am outside the state of Alabama when receiving Telehealth services so that the clinician or office can determine licensure for said state and/or to determine if Telehealth is permissible.

Payment for Telehealth Services:

Psychiatry South will bill insurance for Telehealth services when these services have been pre-determined to be covered by an individual's insurance plan. However, not all pre-determinations are accurate or guaranteed. In the event that insurance does not cover telehealth, the individual wishes to pay out-of-pocket, or when there is no insurance coverage, a private pay rate will be determined.

Patient Consent to the Use of Telehealth:

I have read and understand the information provided above regarding Telehealth, have discussed it with my clinician, and all of my questions have been answered to my satisfaction. I have read this document carefully and understand the risks and benefits related to the use of Telehealth services and have had my questions regarding this service, explained. I hereby give my informed consent to participate in the use of Telehealth services for treatment. By my signature below, I hereby state that I have read, understood, and agree to the terms of this document.

Printed Name: _____ **Date of Birth:** _____

Signature: _____ **Date Signed:** _____