PsychiatrySOUTH

New Patient/Client Registration Form

_____ _____ _____ **Date of Birth:** _____/_____/_____ **Gender:** ____
Last **Middle** **First**

_____-_____-_____ **Marital Status**: _____ **Address:** _____
Social Security Number _____
_____
(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 (*Circle*)**:Hispanic or Latino // Not Hispanic or Latino // Unk or Decline

Race (*Circle One*): 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:

_____ _____ _____ **Relationship to Patient:** _____ **DOB**: ___/___/___
Last **Middle** **First**
Do you have a POA (Power of Attorney)? Yes or No If yes, please provide a copy to the staff.

Emergency Contact(s):

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

Insurance Information (Primary):

Are you using any type of EAP (*Employee Assistance Program*) options? Y or N *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: _____

PsychiatrySOUTH

General Practice Policies

Appointment Policy

Appointments are a mutual commitment between the patient and the clinician. Patients are responsible for managing and attending their scheduled appointments.

- A minimum of 24 hours' notice is required to cancel or reschedule appointments.
- Appointments cancelled with less than 24 hours' notice, late cancellations, or no-shows may result in a fee.
- Arriving late does not extend the appointment time and may result in rescheduling or shortened services.
- Repeated late arrivals, cancellations, or no-shows may result in dismissal from the practice.

Patients are expected to arrive on time, at least 15 minutes prior to scheduled appointment. and prepared for their scheduled appointment. ***Initials*** _____

Payment for Services

Psychiatry South will bill primary insurance when applicable. Patients are responsible for:

- All copayments, deductibles, coinsurance, and balances
- Charges for services not covered by insurance
- Full payment at the time of service if insurance is not billed

Accepted forms of payment include cash, debit cards, and major credit cards. Failure to maintain a current payment method or resolve balances may result in suspension of services or dismissal from the practice. ***Initials*** _____

Confidentiality

Psychiatry South operates using a multidisciplinary team-based model, meaning clinical information may be shared internally among providers for continuity and quality of care. Information will not be released outside the practice without written authorization, except as required by law, including but not limited to:

- Risk of harm to self or others
- Abuse or neglect (child, elder or dependent adult)
- Court orders or legal requirements

Patients must complete a Release of Information (ROI) to authorize communication with outside parties. ***Initials*** _____

Communication and Office Response Times

- Routine clinical and administrative messages are handled during normal business hours.
- Please allow 48–72 business hours for responses.
- Clinicians are not continuously available and may not be in the office daily.
- Messages should not be used for emergencies or urgent concerns.

After-Hours & Emergencies

- After-hours services are reserved for true psychiatric emergencies only.
- Medication refills, appointment changes and non-urgent matters are not handled after hours.
- In an emergency, call 911 or go to the nearest Emergency Department.

Misuse of after-hours or emergency services may result in corrective action, additional charges and/or dismissal. ***Initials*** _____

Laboratory Policy

- Labs, imaging, or diagnostic testing may be required to ensure safe and effective treatment.
- Patients are responsible for completing required testing in a timely manner.
- Failure to complete testing may result in delayed or discontinued treatment.

Costs not covered by insurance are the patient's responsibility. ***Initials*** _____

Medication & Controlled Substance(s)

- Medication management requires regular follow-up appointments.
- Refills are not guaranteed without compliance with visits, documentation and treatment plans.
- Controlled substances require strict adherence to federal and state regulations.

Patients prescribed controlled medications may be required to complete UDS scereening, participate in pill counts, use singular pharmacy and comply with PDMP monitoring. Failure to comply may result in discontinuation of medications or dismissal from the practice. ***Initials*** _____

Professional Conduct & Respect

Patients are expected to maintain respectful behavior toward staff and providers.

- Verbal abuse, threats, harassment, or inappropriate behavior will not be tolerated.
- Disruptive or unsafe conduct may result in immediate dismissal. ***Initials*** _____
- Patients may be dismissed for reasons including, but not limited to:
- Repeated missed appointments or late cancellations
- Non-compliance with treatment plans
- Abuse of staff or providers
- Failure to pay balances
- Misuse of after-hours services

If dismissed a written notice will be sent on the portal and last known address, emergency coverage will be provided for 30 days and records will be forwarded upon receipt of valid release. ***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:** _____

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

Appointments are a reserved time specifically for you and your provider. Missed appointments limit access to care for other patients and disrupt clinical operations.

Patient Responsibilities

- Patients are responsible for attending all scheduled appointments.
- A minimum of 24 hours' notice is required to cancel or reschedule any appointment.
- Cancellations made with less than 24 hours' notice, failure to appear ("no-show"), or repeated late arrivals may result in fees and/or corrective action.

Fees

- The initial missed appointment or late cancellation may result in a fee of $75.00.
- Subsequent occurrences may result in fees ranging from $100.00–$210.00, depending on appointment type and duration.
- These fees are not billable to insurance and are the sole responsibility of the patient.

Habitual Non-Attendance

- Patients with more than three missed appointments (late cancellations or no-shows) may be subject to dismissal from the practice.
- Repeated failure to attend scheduled appointments may also result in limited scheduling privileges or transition to same-day scheduling only.

Payment of missed appointment fees is required before future appointments may be scheduled.

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 treatment at Psychiatry South, medications may be prescribed as part of your care plan. Medication management requires ongoing follow-up, compliance and communication.

General Refill Guidelines

- Medication refills must be requested during scheduled appointments.
- Patients are responsible for scheduling follow-up appointments before medications run out.
- Refill requests will not be honored if appointments are missed or overdue.

No After-Hours or Weekend Refills

- Medication refills are not processed after hours, on weekends or on holidays.
- Refill requests submitted outside of business hours will be addressed on the next business day, if appropriate.

Missed Appointments & Refills

- Failure to attend scheduled appointments or repeated cancellations may result in denial of medication refills.
- Requesting refills without appropriate follow-up is considered non-compliance and may result in dismissal from the practice.

Controlled Substances (Stimulants, Sedatives, etc.)

Controlled medications (including but not limited to stimulants such as Adderall, Vyvanse, Concerta, etc.) are subject to strict federal and state regulations.

Patients prescribed controlled substances agree to the following:

- Prescriptions are issued on a month-to-month basis
- Appointments must be kept as scheduled
- Medications must be filled at a single designated pharmacy
- Lost, stolen or damaged prescriptions will not be replaced
- Early refills will not be approved

Patients may be subject to:

- Random urine drug screening (UDS)
- PDMP (Prescription Drug Monitoring Program) review
- Additional compliance measures as required by law

Failure to comply with these requirements may result in discontinuation of controlled medications or dismissal from the practice.

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: _____**

PsychiatrySOUTH

Controlled Substance(s) Contract

Controlled substances (including but not limited to stimulants, benzodiazepines, sedatives, and certain pain medications) may be an important part of treatment but carry a risk of misuse, diversion, and dependency. These medications are regulated by federal and state law. As a patient of Psychiatry South, I understand and agree to the following conditions. ***Each section must be initialed.***

1. Patient Responsibility

I understand that I am solely responsible for the safe use, storage, and accountability of any controlled substance prescribed to me.

- Lost, stolen, damaged, or prematurely used medications will not be replaced.
- Early refills will not be provided. ***Initials:*** _____

2. Prescription & Refill Rules

- Controlled substances are prescribed on a month-to-month basis.
- Prescriptions are issued only during regular business hours and during scheduled appointments.
- Refills will not be provided after hours, on weekends, or on holidays.

Failure to attend scheduled appointments may result in denial of refills. ***Initials:*** _____

3. Compliance Monitoring

I agree to comply with all monitoring measures required for safe prescribing, including but not limited to:

- Random urine drug screening (UDS)
- Pill counts
- PDMP review
- Additional testing when clinically indicated ***Initials:*** _____

4. Prohibited Use & Diversion

I agree:

- Not to sell, share, lend, or give my medication to anyone
- Not to alter how I take my medication without provider approval
- Not to obtain controlled substances from any other provider without notifying my treating clinician ***Initials:***_____

5. Substance Use

I understand that the use of non-prescribed, illicit, or recreational substances (including marijuana, cocaine, non-prescribed opioids, or misuse of alcohol) may be incompatible with controlled substance treatment.

Evidence of substance misuse may result in:

- Discontinuation of controlled medications
- Referral for higher level of care
- Dismissal from the practice ***Initials:*** _____

6. Pharmacy Requirements

- I agree to use one designated pharmacy for all controlled substances.
- Controlled medications must be filled at an Alabama-licensed pharmacy, unless otherwise approved.
- Any pharmacy change must be reported before prescriptions are issued.

Pharmacy Name: _____

Pharmacy Phone: _____ ***Initials:*** _____

7. PDMP Acknowledgment

I understand that Psychiatry South participates in and routinely reviews the Alabama Prescription Drug Monitoring Program (PDMP) to monitor controlled substance prescribing and dispensing. ***Initials:*** _____

8. Appointment & Conduct Requirements

I agree to:

- Keep scheduled appointments
- Follow office policies, including payment and attendance policies

Treat staff and providers with respect ***Initials:*** _____

9. Violation & Termination of Agreement

I understand that violation of this agreement—including non-compliance, falsification, misuse, diversion or obtaining controlled substances from other sources—may result in:

- Immediate termination of controlled substance prescribing
- Referral to appropriate authorities when required
- Dismissal from Psychiatry South

This decision is at the clinical discretion of the provider and may occur without appeal. ***Initials:*** _____

Acknowledgment & Consent **Date: ___ / ___ / _____**

Printed Name: _____ DOB: ____/_____/____ Patient Signature: _____

Provider 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:** _____/_____/_____