PsychiatrySOUTH

2026 Established Patient Update

All areas must be filled out

Patient Name *(legal name or as listed on insurance)*:_____

Preferred Name *(if applicable)* :_____ **Marital Status:** _____

Date of Birth: _____/_____/_____**SSN**: _____-_____-_____ **Employer:** _____

Address: _____ **Home Phone**: (_____) ____-____ **Leave Msg? Y / N**

_____ **Cell**: (_____) _____-_____ **Leave Msg? Y / N**

_____ **Email Address**: _____@ _____

Pharmacy Name: _____ **Pharmacy Number:** (_____) _____-_____

Emergency Contact and Release of Information Verification:

Name: _____ **Relationship:** _____ **Phone Number:** (___) ____-_____

Have there been any changes to whom we may release information to? *(circle)* **Y / N**

*If **yes**, please see a member of the staff immediately to update your record to help us honor your wishes and protect your PHI and confidentiality.*

Identifying Information:

Preferred Language:_____ **Ethnic Group (*Circle*):**Hispanic or Latino // Not Hispanic or Latino // Unk or Decline

Sexual Orientation: _____ **Gender Identify** *(if applicable)*:_____

Race (*circle*): Caucasian or White // African American or Black // Asian // American Indian or Alaskan Native Native Hawaiian or Other Specific Island // Other Race

Have there been any changes to your insurance? Y or N

*If **yes,** please complete the information below, **if no, skip** to signature/date at the bottom of the page.*

Please note that failure to provide accurate insurance information at the time of your visit or prior may result in delayed claims filing and possible ultimate self-responsibility for services. You are responsible for giving correct coordination of benefits and policies.

Insurance Information (Primary):

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

Insurer Name *(Insurance Company Name)*: _____ Subscriber ID: _____

Group Number: _____ Authorization Number: _____

Subscriber Name *(If different from self)*: _____ Relationship to Patient: _____

Subscriber Date of Birth: _____/_____/_____ Subscriber Social Security Number: _____-_____-_____

Subscriber's Employer: _____

Generally we do not accept secondary insurances unless you have Medicare primary. See a staff member to inquire about secondary insurance specifics.

Date: _____/_____/_____

Printed Patient Name: _____**Signature Of Patient**:_____

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

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:** _____

PsychiatrySOUTH

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 and 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: _____**

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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: _____/_____/_____