Thank you for coming back to join our practice and we are sorry for the inconvenience that extra paper work might cause. Our goal is to be informed about your current status and how to better serve you.

Please Print:

Name: ____ DOB: _____/_____/____________

Date of last visit with us in months: _____________ Clinician (Dr.) Name: ________________________

Reason for your extended absence from our practice:

____
____
____

Purpose of returning to our practice:

☐Medication Refills ☐Medication Management (change, adjust)

☐Manage my illness ☐Manage my current stressors

☐ Others: ____

Please update us since your last visit:

Medication Changes ☐ No ☐ Yes, explain: ____
____

Hospitalization ☐ No ☐ Yes, explain (when, where, why): ____________________________________
____

Change in Life Circumstances (check all that apply)

☐ Living Situation ☐ Job ☐ Education ☐ Relationships ☐ Legal ☐ Other: _________________

Would you like to add any other information that would be helpful to know? ☐ No ☐ Yes
____
____

Patient Name: ______________________________

Signature: ____ Date: _____/_____/__________

Notice of Professional Psychiatric Services
General Office and Financial Policies

Patient Name:_______________________________________ **D.O.B.**______/_______ /_____

We believe it is in the best interest of your care to keep you informed of our office policies. Please carefully read each item below and initial each item if you do not have any questions, followed by your signature at the bottom of page 2. If you have any questions, our staff will be happy to help.

1. All patients who do not have commercial insurance, or have insurance that we are not contracted with, are expected to pay in full at the time services are rendered._____**(initial)**

2. For all patients with a commercial insurance policy for a carrier we are contracted with, we will file with your primary insurance company and accept payment per our contracted rate. We will file to your secondary claim up to two times. If we have not received payment after the second filing, the balance will become patient responsibility. You must file your tertiary insurance claims yourself. For any services rendered which are unbillable to your insurance; you will be notified in advance, and payment from the patient is expected at the time of service _____**(initial)**

3. Prior to your visit at our office, we will contact your insurance company to verify your benefits under your plan. Please remember that each individual plan is different so we will never know exactly how your insurance will pay your claim until it is processed by your insurance company. With the information you provide, we will be able to determine the approximate payment due at the time services are rendered as well as learn of any authorizations required by your plan. _____**(initial)**

4. You agree to provide our office with any changes in insurance. You agree to provide us with a copy of your insurance card any time there is a change. If we do not have the correct insurance information on file, you will be responsible for the full amount owed. _____**(initial)**

5. If you have a copay, it must be paid in full at the time of your visit. This is in accordance with your insurance agreement. If you have a deductible and it has not yet been satisfied, you must pay 100% of the billed charges at the time of your visit. If you have a co-insurance plan, you will be charged a percentage of the billed charges for your visit. _____**(initial)**

6. In the event of an overpayment, you may choose to have the funds refunded to you or we can apply them to future dates of service. However, refunds less than $100.00 will not be issued if there are outstanding insurance claims. _____ **(initial)**

7. In the event of a balance due, we request that payment and/or arrangements be made within 30 days. The office will mail out statements monthly. It is your responsibility to ensure that we have the correct address on file. Our office will also keep you informed of any balance you may have. It is our policy that the ability to receive services might be suspended if your current balance exceeds $200 unless a payment agreement is in writing and is approved by the office manager to overcome the unpaid balance. If you have a question regarding your balance, please contact the billing department. _____ **(initial)**

8. Please remember that, just as PPS has a contract with your insurance company, you do as well. In order for us to be contractually obligated to accept the payment and discounts your insurance offers you, you must follow the guidelines set forth by your insurance carrier. It is your responsibility to participate in the insurance guidelines, which includes prompt payment of services rendered, or your contract may be voided.
____ **(initial)**

Notice of Professional Psychiatric Services
General Office and Financial Policies page 2

Patient Name:______________________________________ **D.O.B.**______/______ /_____

9. Visit Authorizations: PPS will keep track of the number of visits in regards to any authorizations required by your insurance. However, please be aware that this is also your responsibility. You are required to know the benefits of your plan, the number of visits allowed, and if further authorizations are required. _____ **(initial)**

10. Appointment Reminders: As a courtesy, PPS will set up automated appointment reminders. You will receive a reminder text at least 48 hours prior to your upcoming appointment. It is your responsibility to provide PPS with the correct phone number for the automated texts. Therefore, our no show/late cancel policy is strictly enforced. You will be charged $60.00 per missed visit/ late cancel visit unless you call us 24 hours before your appointment. _____ (**initial)**

11. Re-establishing services: If you are not seen at the regularity of your provider's request or within a 3-month window, you will be considered discharged from the agency and will be required to re-establish as a new patient if you want to restart services. If you are participating in our OMT program and are not seen in over a month you may be required to re-establish as a new patient. _____ **(initial)**

12. Form Requests / Medical Records: If you need forms completed or records sent outside of the office, we will be happy to do so. You will need to schedule a specific paperwork appointment in order to get forms completed by your provider. Records requests will be executed within 30 business days of your signing the release form. *Please ask staff for a Release of Information Form*. There is a charge per page and/or per request. There is an additional fee if you need the request expedited. All of these charges are in line with industry standards, and are usually not covered by your insurance. Payment is expected for these services at the time of the request. _____ **(initial)**

By signing below, I agree that I have ready and understand the financial policies above. I understand that I am responsible for all charges that are not covered by my insurance, an in the event of a no show/late cancel or form requests/medical records request; these charges are completely my responsibility and my insurance carrier/third party payor will not be billed.

____ _______ /_________/ ________
Patient Printed Name **Date**

____
Patient / Parent / Legal Guardian Signature

PATIENT INFORMATION

DATE: ______________________

Patient's Name: ____Date of Birth: ___________________
Street Address: ______________________________________City_____________State: __________Zip:__________
Cell Phone # : (   ) ______________ Home Phone #: (   ) ______________ Work # : (   ) ______________
Social Security #: __________________ *Sex*:   M   F   Marital Status: _____________ Race: ______________
Patient's Employer: ____ Occupation: __________________
Contact in Case of Emergency: ____ Phone # : (   ) ______________
Family Doctor: _________________________________ Referring Doctor: __________________________________

Preferred Contact Phone #: (   ) ______________ PPS may leave PHI on my answering machine /voicemail: □Yes □No
PPS may leave the following: □ appointment information □ detailed information □ test or lab results □ response to my inquiry /question
Email Address: ____ PPS may email appointment reminders: □Yes □No

Insurance Information: Please give receptionist your card(s)
Primary Insurance: ____ Phone #: (   ) __________________
Insured Name: ____ Relation to Patient: __________________
Insured Policy ID#: ____ Group # : ___________________________
Insured DOB: ____________ Insured Employer: _______________________________ Insured S.S.#: _________________
Insurance coverage provided through □ Employer □ Individual Policy □ Workers Comp □ Auto Accident Policy
Secondary Insurance: ____ Phone #: (   ) __________________
Insured Name: ____ Relation to Patient: __________________
Insured Policy ID#: ____ Group # : ___________________________
Insured DOB: ____________ Insured Employer: _______________________________ Insured S.S.#: _________________
Insurance coverage provided through □ Employer □ Individual Policy □ Workers Comp □ Auto Accident Policy
If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other: ____________

If Patient is a Minor:
Mother's Name: ______________________________ Date of Birth: ______________ Home PH # (   ) ____________
Mother's Employer:____________________________ Bus. PH #: (   ) ____________ Social Security # :____________
Father's Name: ______________________________ Date of Birth: ______________ Home PH # (   ) ____________
Father's Employer:____________________________ Bus. PH #: (   ) ____________ Social Security # :____________

Please read and sign below:
I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatment to Blue Shield or other insurance carriers and authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program or my insurance carrier.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review / audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's **PRIVACY POLICY** ______________________ (INITIAL HERE)
I have reviewed the **OFFICE FINANCIAL POLICY** ______________________ (INITIAL HERE)
I have reviewed the **CONSENT for TREATMENT** ______________________ (INITIAL HERE)
I understand that copies are available upon request.

Signature: ____ Date: ______________________
If this is a worker's compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork.
PRIVATE INSURANCE REQUIRES A COPAY TO BE PAID AT THE TIME OF SERVICE, if applicable.

PATIENT NAME: ____________________________

DOB: ______/________/_______

SS#: ____________________________

CONSENT TO TREAT

I hereby certify that Professional Psychiatric Services Physician, Clinician or Independent Contractor providing services has informed me of their professional qualifications, certifications and/or licensure; has provided both an explanation of client's rights and responsibilities, has made the privacy notice available and has informed me of their assessment, diagnosis, and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended.

Patient Signature	Date	Physician, Clinician or Independent Contractor	Date

If treatment is for a minor,

I ____ custodial parent / legal guardian of:
(Name of parent/legal guardian)

____, age _______________, authorize
(Name of Minor) (Age of Minor)

Professional Psychiatric Services to assess and treat my child in an outpatient mental health setting. I agree to take part in the process as needed, and understand the forma of treatment nay include any combination of the following: individual sessions with minor child, family sessions and sessions with parental unit(s).

Parent/Legal Guardian Signature	Date	Physician, Clinician or Independent Contractor	Date