ACCESS PSYCHIATRIC AND BEHAVIORAL SERVICES

(PLEASE PRINT)

Date_____ Home Phone (_____) _____

Patient Information

Email: _____

Name_____ SSN/MIC/Patient # _____
Last Name First Name Middle Initial

Address_____ Cell Phone (_____) _____

City_____ State_____ Zip _____

Sex ☐ M ☐ F Age_____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for ___ yrs

Patient Employer/School_____ Occupation _____

Employer/School Address_____ Employer/School Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency who should be notified?_____ Phone (_____) _____

Primary Insurance Information

Person Responsible for Account_____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate_____ Social Security _____

Address (if different from patient) _____ Phone (_____) _____

City_____ State_____ Zip _____

Person Responsible Employed by_____ Occupation _____

Business Address_____ Business Phone (_____) _____

Insurance Company _____

Member ID # _____ Group # _____ Contact # _____

Names of other dependents covered under this plan _____

Additional Insurance Information

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Phone (_____) _____

City_____ State_____ Zip _____

Subscriber Employer by _____ Business Phone (_____) _____

Insurance Company _____ Soc. Sec. # _____

Member ID # _____ Group # _____ Contact # _____

Names of other dependents covered under this plan _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to

Dr._____ all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named physician may use my health care information and may disclose such information to the above-named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefitsor the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to patient

Registration form

Access Psychiatric and Behavioral Services

Welcome to our office. We would like to thank you for the opportunity to provide your outpatient psychiatric care. We have listed below some general information about our practice and our office Procedures. If you have questions that are not answered below, please feel free to contact us.

Office Policies

Office Hours:

- Please be mindful of our office hours. They are subject to change without prior notice. For this reason Walk-Ins are discouraged. Please call ahead to schedule the best time to arrive for an appointment.

Medication Refill Policy:

- You must notify the doctor during your visit if you need a prescription renewal. Refills will no longer be issued by phone request.
- Prescriptions will be refilled at each **appointment**, following re-evaluation of your condition and medical needs, and we will provide you with at least sufficient medication and refills to extend until the next scheduled appointment. In the event of an emergency (e.g., while out of town or on weekends) small amounts of medication may be available directly from a pharmacist.

Controlled Substances:

- Prescriptions for controlled substances (stimulants or benzodiazepines) WILL NOT BE REISSUED until the date the prescription is due to run out. You are responsible for safeguarding your prescriptions and medications.

Emergencies:

- None of our providers are on call. We do not provide emergency Psychiatric care. We are not open 24 hours. During normal business hours, the receptionist will facilitate setting up an appointment. If it is outside of normal business hours, call the office and **leave a message** with your name, the patient's name (if different), the best contact number at that time, and the emergency issue. The office will return your call as soon as possible. If you cannot wait, for an appointment you should call 911 or go to the nearest emergency room for urgent treatment.

Appointments:

- You must be able to present a copy of your current insurance card and/or military identification at each and every visit.
- Please be on time for your appointment if you are late to your scheduled appointment you may, at the discretion of the staff, be asked to reschedule.
- For ***Psychiatrist*** being more than 10 minutes late without notification will have to be rescheduled, all fees apply.
- If you are 15 minutes late for a ***Therapist*** appointment you will have to reschedule and pay a late fee of $60 or your session time will be deducted. A late fee will be charged.
- We reserve the right to reschedule appointments if needed.

Access Psychiatric and Behavioral Services

Reminder Calls:

- As of August 2015 we are no longer making reminder calls. It is important to our practice and your health that you keep your appointments. Please take responsibility and record your appointment in the best way you can. We can provide you with an appointment card if you schedule in person or an email if you provide it to us. We are in no way shape or form responsible for your appointment, any effort made to remind you is a courtesy, not an obligation and staff is not at fault if no such courtesy is provided.

Telephone policy:

- To uphold the quality of care and in fairness to all, our providers cannot take time from patient appointments to accept or return patient's phone calls. While in session our providers must allocate their time to patients. A receptionist can take your call and leave a message. However, if you feel you must speak with the doctor, please make an appointment.
- We take pride in answering your call in person whenever possible. However, there are times when heavy call volume may prevent us from speaking with you directly. If you get a recording, you will obtain the best results by observing the following directions:
    - Plan ahead and call once. Multiple calls keep the line busy and do not allow for us to assist you further.
    - Keep your message as brief as possible (name, number and reason for call). For example; "Jane Doe, 555-1212, I need to reschedule my appointment."
    - Allow up to 72 hours for a return call, especially if you call late in the day.

- Medical issues will not be addressed over the phone. Please make an appointment.
- Office Staff will be polite and respectful. They deserve the same in return.
- **Abusive and harassment calls are not tolerated. All threats are reported to the authorities.**
- *Please note:* If a voice message is not left we have no way of knowing you called, and therefore cannot get back to you.

Code of Conduct

- As a courtesy to other patients and staff, we ask that cell phones be silenced prior to entering the building. Cell phone conversations are not allowed within the medical office.
- Patients and their family members are required to maintain acceptable conduct at all times. Any patient who is disrespectful of any staff member or other patients will be asked to leave the practice and seek future medical care elsewhere.
- I understand that no profanity or verbal abuse will be tolerated towards the providers, staff of this office or other patients. This would be grounds for my discharge from the practice.
- I understand that any damages incurred to office equipment, furniture or displays are grounds for discharge from the practice or repair fees.
- Due to the sensitivity of different people, we ask that you not wear strong scented fragrances.

Access Psychiatric and Behavioral Services

Please sign that you have read, understand and agree to the Office Policies and Code of Conduct below.

_____

Patient Name (Please Print) **Date of Birth**

_____

Signature of Patient or Patient Representative
Date

Cancellation/ No Show Policy

We understand that situations arise in which you cannot make it to your appointment. It is therefore required that if you must cancel your appointment you provide more than 24 hours' notice. This will allow for a patient in need of an appointment to be scheduled. When cancellations are made with less than 24 hours' notice, we are unable to accommodate others.

- All cancellations or rescheduling of an office visit must be received ***at least 24 hours prior*** to your appointment time. If you cancel or reschedule within 24 hours, you will be charged a non-cancellation fee.
- If at any time you DO NOT cancel or reschedule your appointment at least 24 hours prior to your appointment time, there will be a non-cancellation fee charged to your account.
- We may attempt to confirm your appointment, but not having your appointment confirmed does not waive your responsibility to cancel or reschedule at least 24 hours prior to your appointment.
- Also, please note that calling to cancel or reschedule on the day of the appointment does not waive the non-cancellation fee charge. This fee also applies to same day appointments that your fail to show up for. These ***charges will not be waived by any provider*** and is enforced at the front desk with the receptionist.
- To avoid fees for missed appointments, you must **show up on time**, or call at least 24 hours before your appointment to cancel or reschedule. Being late to your appointment may result in having to reschedule as well as a fee, especially if we are closing.

Patients who do not show up for their appointment without a call to cancel an office appointment will be considered as "No Call No Show" (NCNS). Patients who No-Show three (3) or more times in a 12 month period, will be responsible for the incurred charges, dismissed from the practice and denied any future appointments.

We understand that special unavoidable circumstances may cause you to be a "No Show". Fees in this instance may be discussed with staff and waived with appropriate documentation. Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication.

Access Psychiatric and Behavioral Services

- Charges are as follows:
  - Physicians and Nurse Practitioner will be $35.00
  - Therapist will be $60.00
- **NOTE:** These "No Call No Show" fees are the sole responsibility of the patient , ***insurance will not pay*** them. Fees are the patient's responsibility and must be paid in full before the patient's next appointment. Charges are subject to change with our policies, please keep yourself informed of our policy changes.

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____

Patient Name (Please Print) **Date of Birth**

_____

Signature of Patient or Patient Representative
Date

Patient Responsibilities

- We do not check your insurance eligibility. It is your responsibility to give us your most recent insurance, and to make sure that we are listed under your policy.
- The patient will make every attempt to understand the benefits of my insurance plan, even to the extent of calling the insurance carrier, to verify that this office is a participant under my plan and to find out what services will and will not be covered. Patient also agrees that if the procedures performed are not covered by my insurance, he/she will accept responsibility of payment for services rendered.
- Please notify us of any changes of address, phone number, or Insurance.
- IF YOU HAVE NEW INSURANCE PLEASE NOTIFY OUR OFFICE PRIOR TO YOUR NEXT APPOINTMENT. If you fail to notify us in advance with your new insurance you may be asked to reschedule and or pay for visit out of pocket.

Financial Policies

- If you have an account balance, you must pay your balance prior to your appointment with any provider.
- If you have insurance, your insurance as well as any secondary insurance you may have will be billed for you. You will be responsible for any deductibles and all non-covered services etc., according to your benefits.
- Please note that for certain insurance plans some aspects of care are not covered expenses and will be made your responsibility. It is your responsibility to know your benefits.
- Co-Payments or Payments for Self Pay visits are due prior to services being rendered. Your co-pay cannot be waived or billed.
- Patient balances that are 30 days past due must be paid before another appointment can be made. Patient balances that are over 60 days will be sent to collections. Once a patient is sent to collections no further appointments can be made or kept until the balance has been paid.

Access Psychiatric and Behavioral Services

- I understand that Access Psychiatric and Behavioral Services will submit the charges incurred at this office to my insurance carrier. This is done as a courtesy to me. If after 30 days, from date of service, my insurance carrier has not paid for the visit, I will be held responsible for the balance of the bill. Ultimately it is my responsibility to make sure my insurance is paying in a timely manner.
- Payment in full of all co-pays, deductibles or visit charges is due at the time service is rendered. Our office accepts major credit cards and cash in **exact change**. **We do not accept checks**.
- There is a $35 fee for checks returned for insufficient funds. We do not accept checks however in special cases in the event that we do accept. Should your check be returned by my bank (e.g. insufficient funds), I agree to pay a $35.00 returned check fee as well as any clerical fees involved.
- For your convenience we do except over the phone payments and credit cards on file. However, in cases where a card gets declined for a scheduled payment, a clerical fee may apply.
- FMLA/Legal and other paperwork have charges. Payment must be received **before** your paperwork will be processed. Discuss prices with receptionist or manager.

Please sign that you have read, understand and agree to the Patient Responsibilities and Financial Policies below.

_____

Patient Name (Please Print) **Date of Birth**

_____

Signature of Patient or Patient Representative
Date