Psychiatry Associates, P.C.

1736 Oxmoor Road. Suite 103. Birmingham, AL 35209

Telephone: (205) 879-2120

REGISTRATION FORM

Patient's name: ____

Date of birth: ____________________ *Age:* ___________ *Ethnic origin:* ______________________

Marital status: ______________________ *Social Security Number:* ________________________

Responsible party *(relation):* ____

Date of birth: ____________________Social *Security Number:* ____________________________

Address: ____

City: __________________________________State: _______________ Zip code: _____________

Telephone #: *(H)* _________________ *(W)* ___________________ *(Mobile)* _________________

Insurance: _____________________________ *Policy #:* __________________________________

Employer: _____________________________ *Group #:* __________________________________

Custodian *(relation):* ____

Date of birth: ____________________ *Age:* ___________ *Ethnic origin:* ______________________

Marital status: ______________________ *Social Security Number:* ________________________

Address: ____

Telephone #: *(H)* ___________________ *(W)* __________________ *(Mobile)* ________________

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay for any services not covered by your contract, deductible amount, co-insurance or any other balance not paid by your insurance. **Companies will not reimburse you for charges concerning late cancellations or missed visits.**

Payment is due at the time of service unless you are covered by one of our contracted insurance carriers. *Any account 120 days in arrears will be assigned to a collection agency or attorney.* I agree to pay a reasonable attorney's fee and cost of collection**. Failure to meet your financial obligations may result in termination of clinical services.**

To the extend necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record. I hereby assign all medical benefits, to include major medical benefits to which I am entitled, including private insurance, and other health plans to Psychiatry Associates, PC.

This assignment will remain in effect until revoked by me in writing. A photocopy of the agreement is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure payment.

Signed ____ Date ____________________

CONSENT FOR TREATMENT

I, ______________________________, agree and consent to receive mental health services under the care of Psychiatry Associates, PC. I understand that I may revoke this consent at any time. Confidentiality of all communications between me and Psychiatry Associates, PC will be maintained except disclosure authorized by me in writing or as required by law or emergency circumstances. I have read the Patient's Bill of Rights and Office Policies, and understand and appreciate my clinical rights and responsibilities. I am aware that copies of the Patient's Bill of Rights and Office Policies are posted at the waiting room and website of Psychiatry Associates, PC.

I give the staff of Psychiatry Associates, PC the permission to contact __________________________

_________________ (Telephone: ____________________) in the event of an emergency.

Signed ______________________________________ Date __________________________

CONSENT FOR TREATMENT OF MINOR CHILDREN

I hereby declare that I hold custody of my minor child, ______________________________, and give consent for my child to receive mental health services under the care of Psychiatry Associates, PC. I have read the Patient's Bill of Rights and Office Policies, and understand and appreciate my clinical rights and responsibilities. I am aware that copies of the Patient's Bill of Rights and Office Policies are posted at the waiting room and website of Psychiatry Associates, PC. I understand that if a youngster is **18 YO and older they are expected to handle their own appointments.**

Signed ____ Date ____________________

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OFFICE POLICIES

NORMAL OFFICE HOURS:

- Monday through Thursday: 9:00 a.m. to 5:00 p.m. Friday: 9:00 a.m. to 12:00 Noon.
- We close from 12:00 Noon to 1:00 p.m. for lunch.

EMERGENCIES:

If you have a life-threatening medical emergency and you are unable to immediately contact your doctor or any of the office staff, **please go to the nearest emergency room**.

TELEPHONE CALLS AND ON-LINE CONSULTS:

Telephone calls between appointments are reserved for pressing psychiatric issues. Your doctor can be reached by calling our office number. If your doctor is unavailable please leave a message with the secretary or answering service. Your call shall be returned as soon as possible.

You may request your doctor to contact you after business hours. **Please make sure that your phone is accessible to private callers** -those who do not identify themselves with a "Caller ID."-.

Many problems may be dealt with by advice over the telephone or internet. *Please note that fees are applied to on-line consults or telephone calls lasting 5-10 minutes or longer*, and that most insurance companies do not reimburse for this service.

PRESCRIPTION REFILLS:

It is very important that you follow the doctor's orders related to medications. You or your pharmacist must call the office for refill authorization. All requests for medication **refills will be handled within 48 hours during normal business hours**. *Please remember to request refills one week prior to taking the last of the medication*. Some medications require new written prescriptions from your doctor and cannot be processed over the telephone or fax. **Requests cannot be processed after business hours, on weekends or holidays.**

APPOINTMENTS, "NO SHOW" & LATE CANCELLATIONS:

Patients 18 YO and older are expected to handle their own appointments. **Cancellations must be made 24 hours in advance to avoid a charge**. If you fail to show or cancel the same day of your appointment you will be *charged 100% of the customary fee.* If you cancel the day prior but less than 24 hours before your scheduled time you will be *charged 50% of the customary fee*. The charge will be waived if the appointment time can be assigned to another patient. **After two consecutive no-shows or three cancellations, you may be discharged from the clinic.** Insurance companies will not reimburse you for charges concerning late cancellations or missed visits.

FINANCIAL POLICY:

Payment is due in full at the time of service. ***Deductibles and non-covered expenses are collected on the day of the appointment.*** Your billing receipt can be submitted to your insurance company for reimbursement directly to you. The specific amount your insurance company will reimburse varies depending upon your policy. Check with your insurance company to determine the nature of your coverage. Bills are issued for missed appointments and outstanding balances only. Charges for evaluation and/or therapy sessions, on-line or telephone consultations, review of records for diagnosis or treatment, and preparation of reports will be indicated on your bill. All payments for services should be made directly to Psychiatry Associates, P.C. There will be a 30 $ penalty charged for returned checks. We honor payment with Discover, VISA and Master Card. **Failure to meet your financial obligations may result in termination of clinical services.**

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Please sign initials and date

Patients' Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name: ____

Birth date: ______________

The Notice of Privacy Practices of **PSYCHIATRY ASSOCIATES, P.C.** is available in our website.

We make every effort to keep the patient's name and record private. All information concerning a patient's identity or clinical care is released only when instructed to do so by the patient.

If you chose to use your health insurance company, they will receive our statement including the dates of the patient's visit, charges and diagnosis. As part of cost control efforts, insurance companies may ask for more clinical information, however. We will let you know if this should occur and what information the company has requested.

In all but few rare situations, your privacy is protected by state law and the ethical code of psychiatry. For minors who are mature enough to come unaccompanied by their parents to the clinic, confidentiality of information disclosed during their examination and treatment is respected.

I acknowledge that I have received a copy of Notice of Privacy Practices of Psychiatry Associates, P.C. effective April 14, 2003.

Signature (patient or authorized representative):_________________________________

Relationship/authority (if signed by authorized representative): ___________________

Date: _________________