RELIANT FAMILY
Comprehensive Psychiatry Services

Patient Demographic Information Form

Patient Name: _____

Date of Birth: _____ Age: ____ Sex: [ ] Male [ ] Female [ ] Other

Address: _____

City: _____ State: _____ ZIP: _____

Phone (Home): _____ Phone (Cell): _____

Email Address: _____

Primary Insurance: _____ Policy Number: _____

Secondary Insurance: _____ Policy Number: _____

Referring Provider: _____

Address:_____

Phone: _____

Fax: _____

Primary Care Provider: _____

Address: _____

Phone: _____ Fax: _____

Emergency Contact: Name: _____

Relationship: _____ Phone (Home): _____

Phone (Cell): _____

Name: _____ Relationship: _____

Phone (Home): _____ Phone (Cell): _____

contact@reliantpsychiatry.com
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www.reliantpsychiatry.com

RELIANT FAMILY PSYCHIATRY
Mindfulness for a better life

New Patient Medical History Form

Patient Name_____**DOB**_____**Age**_____

Reason for Visit:_____

Medications:

1._____**Dose**_____

2._____**Dose**_____

3._____**Dose**_____

4._____**Dose**_____

5._____**Dose**_____

6._____**Dose**_____

***<u>If you have any more medications, please bring your medication list to your appointment</u>

Allergies: _____

Social History:

Do you smoke? _____Yes_____No **Current Smoker: _____ Packs/Day**

Former Smoker: Quit Date_____

Do you drink alcohol? _____Yes _____No **Number of Drinks per week_____**

Marital Status:____Single ____Married ____Separated ____Divorced ____Widowed ____Partner

Do you have children? ____Yes ____No **If yes, how many? _____**

Occupation_____

Family History

	Diabetes	Hypertension	High Cholesterol	Heart Disorder	Thyroid Disorder	Other
Mother						
Father						
Paternal Grand Mother						
Paternal Grand Father						
Maternal Grand Mother						
Maternal Grand Father						
Siblings						

PA PRIVACY NOTICE FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

1. The Privacy Notice includes a complete description of the use and /or disclosures of my personal health information ("PHI") necessary for the Practice to provide treatment to me, and necessary for the Practice to obtain payment for that treatment and to carry out its health care operations.
2. Practice reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable law.
3. I understand that, and consent to, the following appointment reminders that will be used by the Practice: calling my home and leaving a message on my answering machine or with the individual answering the phone and text messages.
4. The practice may use and/or disclose my PHI (which includes information about my health or condition and the treatment provided to me) for the Practice to treat me and obtain payment for the treatment, and necessary for the Practice to conduct its specific health care operations.
5. I understand that I have a right to request that the Practice restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, Practice is required to agree to any restrictions that I have requested. If the Practice agrees to a requested restriction, it is binding on the Practice.
6. I understand that this Consent is valid and that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocation shall not apply to the extent that the Practice has already acted in reliance on this consent.
7. I understand that if I revoke this consent at any time, the Practice has the right to refuse to treat me.
8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then the Practice will not treat me.
9. The privacy Notice of Reliant Family Psychiatry (the "practice") has been provided to me prior to signing this consent. The practice has explained to me that the Privacy Notice will be available to me in the future at my request. The practice has further explained my right to obtain a copy of the Privacy Notice prior to signing this consent and has encouraged me to read the Privacy Notice carefully prior to my signing this consent. I have read and understood the foregoing notice, and all of my questions have been answered to my full satisfaction in a way that I can understand.

DATE_____ Signature of Patient/ Guardian: _____

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FINANCIAL POLICY

Copayments and Deductibles: All copayments and deductibles will be collected on the day of your appointment, as you check in. All Insurance companies require that physicians collect all co-pays/ deductibles from the patient at the time of service. The arrangement is also part of your contract with your insurance company. We accept payment in the form of cash, Care Now debit or credit card. If you are unable to pay your copay, the office of Reliant Family Psychiatry will hold the right to postpone future office visits until outstanding balances are paid.

Insurance: We are contracted providers for most insurance plans. If you are insured by a plan, we do business with, payment in full is mandatory at each visit. If you are insured by a plan, we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. If your insurance coverage should change, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Claim Submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance for your claim is your responsibility whether your insurance company pays for your claim. If your insurance company does not pay your claim 120 days after your date of service, the balance will automatically be billed to you. Non-Payment If your account is over 90 days past due, you will receive a letter stating you have 14 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated.

Please be aware that if a balance remains unpaid, we will refer your account to a collection agency, and you will be discharged from this practice.

As acknowledged by my signature below, I understand the payment policies of Reliant Family Psychiatry and I also understand that I am financially responsible for all charges incurred regardless of insurance coverage. If the balance on my account is not paid, I agree to bear all interest charges and collection costs.

I also authorize the release of limited medical information to my insurance company, as required for payment of charges and authorized payment of insurance benefits directly.

Date :_____ Signature:_____

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MEDICATION REFILLS POLICY

The following policies are designed to improve the efficiency of the office and communication between you and the staff of Reliant Family Psychiatry. Please read, initial each statement and sign at the bottom of the page to indicate your understanding of the policies.

It is your responsibility to fill your prescription before you run out of medications, and to protect your medications and controlled substances as carefully as you would your money or jewelry. Your pharmacy may not allow refills prior to the prescribed date. Our office does not accept refill requests from the pharmacy itself. _____ (initial)

Reliant Family Psychiatry does not prescribe controlled medications (medication with high abuse potential) for patients with a history of substance abuse, particularly those that the patient has already abused. Also, we do not refill lost, misplaced, stolen or otherwise unavailable controlled medication except under specific circumstances. Repetitive requests of this nature may be declined. It is your responsibility to fill your prescription before it expires. _____ (initial)

Reasons such as:

1. "I went up on the dose on my own."
2. "I went out of town and left my medication behind when I returned home."
3. "The airlines lost my luggage which contained my medications."
4. "My spouse/roommate/girl or boy/friend/son/daughter/pet etc... stole my medication."
5. "I gave a few pills to my spouse/significant other ..... because he or she needed them."
6. "I opened my medication above the sink/ toilet/ pool/ lake..... and it fell in."

These are Not valid reasons for early refills of medication, so please do not ask. In the event your medication is stolen, we do require a police report prior to submission of the refill. _____ (initial)

Per CDC guidelines, refills of prescriptions require periodic office visits with the doctor. It is important to comply with your scheduled doctor's visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Schedule visits must be followed in order for the prescription(s) to be filled.

Please see attached clinic fees list for requesting a refill without an appointment. _____ (initial)

_____ _____

Printed Name Patient/Guardian Signature

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No Show Policy Acknowledgement Form & other fees not covered by insurance

DECLARATION OF AGREEMENT REGARDING MISSED OR CANCELED APPOINTMENT

I understand and agree to the following terms

1. It is my responsibility to notify Reliant Psychiatry if I need to cancel or reschedule a scheduled appointment no less than 24 business hours prior to the scheduled appointment.

2. I hereby agree that I will be billed by my provider $75 in the event that I miss an appointment.

3. Fee for medical records request will depend on the number of pages and delivery format. Paper copies are $25 for the first 20 pages, and 0.50 cents per page after that. Electronic Fax delivery is $25 for 500 pages or less, and $50 for anything in excess of 500 pages. Faxing medical records to another clinic for continuation of care is free of charge with a PHI form filled out allowing us to legally do so. Records placed at the front desk for pick up will be held for up to 30 days before shredding.

4. Fee for letter of Accommodations for school or for Employers, Etc is $30

5. Telephone calls (Consultation) $30 for 15 minutes

6. A letter for a legal office/attorney is $15

7. There will also be a $20 charge for some non-office visit refills of Schedule II Controlled Substance (ex. Adderall, Ritalin etc.) when you are calling in for a refill. This payment must be obtained before sending out your prescription and this can be done via phone, email, or in person. Missing or canceling/rescheduling your upcoming appointments after receiving your refill will require your next visit to be in office. You may request to be seen in accordance with your refill schedule to avoid this fee.

8. Please note that there will be a fee of $50 for any bounced check as the bank takes a processing fee.

9. I understand that these fees are non-covered in-office services and may not be billed to my insurance carrier.

_____ _____

Acknowledgement by Patient (Signature) Date

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Disability/FMLA Paperwork Consent

Effective immediately as per practice policy, any new patient requests for Disability/FMLA paperwork require that the patient be seen at the clinic for a minimum of 3 visits. It is under the provider's discretion to determine if the patient qualifies for disability regarding current psychiatric conditions. This does not guarantee that the patient's employer will approve the claim. All disability/FMLA paperwork is billed to the patient and not their insurance as an in office fee of $150. This fee will be due again if renewal is required after 6 weeks. Payment will be required in full prior to the paperwork being completed.

Thank you for your participation

_____

Acknowledgement/Signature of Patient

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