PSYCHOLOGICAL AND PSYCHIATRIC CONSULTANTS

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PATIENT INFORMATION FORM

Patient Name:_____Today's Date:_____

D.O.B.:_____/_____/_____ Age:_____ Soc. Sec. #: _____/_____/_____

Home Address:_____ Sex: _____M _____F

City:_____State:_____Zip_____Marital Status: S M D W S

Home Phone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Email Address: _____ Occupation: _____

Employer:_____Employer Address: _____

City:_____State:_____Zip:_____

Best mobile phone number to text courtesy appointment reminders:_____

Is it OK to text/ leave voicemails at the above number? _____Yes _____No

RESPONSIBLE PARTY INFORMATION

Full Name:_____Relationship To Patient:_____

Soc. Sec. #:_____/_____/_____ Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Email Address:_____ Occupation:_____

Employer:_____Employer Address:_____

City: _____ State:_____Zip:_____

INSURANCE INFORMATION

Ins. Company:_____ Phone:_____

Behavioral Health Carrier:_____ Phone:_____
(If Different from Primary Insurance Carrier)

Name of Policy Holder:_____Policy Holder DOB _____/_____/_____

Soc. Sec. # of Policy Holder:_____/_____/_____ Relationship to Patient:_____

Member I.D. #: _____ Group #: _____ Employer:_____

Pre-Authorization Needed? _____Yes _____No Date Received:_____

Authorization #: _____ # Visits Approved_____

Co-Pay: $_____Deductible: $_____

PATIENT BACKGROUND INFORMATION

Patient's Primary Care Physician_____Phone #:_____

Presenting Symptoms:_____

Referral Source:_____

Allergies:_____

Medications Currently Taking:_____

Have you received therapy before: Name:_____Phone:_____

Address:_____Was This Helpful:_____

Have you ever seen a psychiatrist: Name:_____Phone:_____

Address:_____

Emergency Contact:

Name:_____Relationship to Patient:_____

Home Phone_____-_____-_____ Work Phone:_____-_____-_____Cell Phone:_____-_____-_____

Informed Consent:

I have received a copy and read PPC's HIPAA Privacy Policy.
I have received a copy of, understand and agree to PPC's Service Agreement.
I consent to Behavioral Health Services at Psychological and Psychiatric Consultants.

Signature:_____ Date:_____
Signature of Patient or Guardian

PROFESSIONAL SERVICES AGREEMENT

I understand that the effectiveness of mental health services depends on efforts of the patient as well as those of the practitioner (Clinician) and I promise to make my best effort to comply with these procedures. These best efforts will include open and honest discussions of my thoughts and feelings, as well as an effort to perform any exercises or homework assignments that may be recommended. I also agree to return, undamaged any materials that have been loaned to me as part of the procedures and understand that I am liable for the cost of these materials. I understand that the effectiveness of the procedures cannot be guaranteed and that the Clinician has sole professional responsibility for all services rendered.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so, I will notify the Clinician at least two weeks in advance so that effective planning for continued care can be implemented. I also agree to notify the Clinician **at least 24 hours in advance** if I will be unable to attend any session. I understand that if I fail to make such notification, I may be charged a late fee of $100.00-$150.00, which will not be reimbursable by my insurance company. I agree to be responsible for these charges.

I understand that conversations with the Clinician will be of a confidential nature. I authorize my Clinician to discuss my treatment with other treatment providers to coordinate my care. I will provide the Clinician with a Release of Information Form allowing them to speak to additional providers for continuity of care. I further understand that the Clinician, by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the Clinician has a legal responsibility to protect anyone that the patient may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the Clinician will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that prescribed medication can only be provided in coordination with regular office visits, in order to provide me with safe and appropriate medical care and that urgent requests by me for medication refills without an office visit may incur a $15 administrative fee, non-reimbursable by insurance.

My signature below indicates that I have agreed to these terms.

_____ _____

(Signature of Patient or Guardian) (Date)

FINANCIAL AGREEMENT

Patients are responsible for providing accurate information about their insurance benefits. Failure to complete this section or inaccurate information will make patients fully responsible for all charges. Patients are responsible for notifying PPC of any changes in insurance within 30 days; otherwise, you will be responsible for payment in full. In most cases, patients are responsible for making the initial phone call to their insurance companies. PPC will make every effort to bill secondary insurance when information is provided.

I request that Psychological and Psychiatric Consultants, as the agent for the Clinician, submit bills to the insurance company that I have listed on the reverse side of this form, and I grant permission to the Clinician and PPC to release such confidential information as is necessary to obtain payment from the insurance company. In the event that my insurance company fails to observe Ohio prompt pay standards or otherwise fails to adhere to relevant rules and standards, I grant permission to PPC to share information related to my insurance claim with the Ohio Department of Insurance.

I understand that I am financially responsible for the cost of the mental health services to me (my child) and for any portion of the fees not reimbursed or covered by my health insurance. If my mental health care is provided under the terms and conditions of a managed mental health care program to which the Clinician is contracted, my financial responsibilities may be limited by the terms of that contract. I understand that my failure to pay these bills may result in collection procedures (including court proceedings) being taken against me by the Clinician or a collection agency contracted by the Clinician to collect these bills. I also understand that if my account is placed in collection procedures, I nor any other patient of PPC for whom I am the guarantor will be able to schedule appointments with any other PPC clinician. Any fee associated with the collection of this debt is the responsibility of the patient or guarantor, including attorney and filing costs.

I understand that the professional services will be rendered to me by _____ (clinician) and that the fee for an initial consultation session will be $_____and the fee for follow-up appointments will be $_____. I authorize release of any medical information necessary to process my claim. Fees may be different for additional services such a psychological testing, legal consultation/testimony, etc. and will be explained to me if these services are necessary.

My signature below indicates I have agreed to the above terms.

_____ _____

(Signature of Patient or Guardian) (Date)