Patient Registration Form

Patient Information

First Name _____

Last Name _____

Date of Birth _____

Address _____

City/State/Zip _____

Phone _____ Alt Phone _____

Email _____

Emergency Contact

First Name _____

Last Name _____

Parent/Spouse/Friend _____

Cell Phone _____ Alt Phone _____

Email _____

☐ Allow communication with contact on your behalf regarding appointments, claims, and prescriptions.

Insurance Information

Insurance Company _____

Member ID #: _____

Group #: _____

Subscriber Name: _____ Date of Birth: _____

☐ I have a secondary OR supplemental plan

Secondary/Supplemental Insurance Information

Insurance Company _____

Member ID#: _____

Group #: _____

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Cancellation and Missed Appointment Policy

Please review our Office Policy regarding cancellations/missed appointments.

A "**missed appointment**" is any scheduled appointment you fail to show up for at the allotted time. Failure to comply will result in a $75.00 penalty, that you are personally responsible for paying. Please be aware that after three missed appointments you are eligible for patient termination.

A "**late cancellation**" is defined when a patient does not give AT LEAST 48 hours' notice of cancellation. Failure to comply will result in a $45.00 penalty that you are personally responsible for paying.

Remember that your appointment time was reserved for you in advance. You are responsible for remembering your appointment date and time. **We require AT LEAST 48 hours' notice if you need to move/cancel/reschedule an appointment.** If it is a family/medical emergency and you are unable to maintain your appointment, we still ask for as much notice in advance as possible. If you are scheduled for a Monday appointment and need to move/change your appointment, please call the Friday prior. By providing the office notice, you are allowing us to fill that time for another patient in need.

Our office software does courtesy reminder calls/texts or emails. This is done by automated software. To receive appointment reminders, you must leave a valid telephone number or email address. Not having a voicemail box set up or a full mailbox is not a valid excuse for any missed appointment, and you will be charged. Not receiving a reminder call/text is not a valid excuse for any missed appointment, and you will be charged.

If you are unable to maintain your previously scheduled appointment, **call the office AT LEAST 48 hours in advance**, to avoid penalties being added to your account. This is a charge that is not covered by insurance. It is critical for our patients to maintain appointments and follow through with their recommended care. **You are responsible for knowing when your appointment is.**

I have read the above information and understand the cancellation/missed appointment policy

Patient Signature: _____

Date: _____

Patient Registration Form

Disclosure of Health Information

This document is to acknowledge the notice of consent authorized by Collaborative Psychiatric Services to use and disclose health information about you for treatment, payment, and health care purposes.

Notice of Privacy Policy: Collaborative Psychiatric Services Notice of Privacy Practices, describes how our office may use/disclose your protected information. As well as giving information on how you can access your protected information. You may review our current notice prior to signing this acknowledgement. (Notice is the Current HIPPA Mental Health standards)

Amendments: We reserve the right to change our Notice of Privacy Practices, to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request.

Acknowledgment and Consent

I have received the notice of Privacy Practices for Collaborative Psychiatric Services. Collaborative Psychiatric Services is authorized to use and disclose health information about my treatment, payment, and healthcare operations consistent with the Notice of Privacy Practices.

Patient Signature: _____

Date _____

Patient Registration Form

Consent for Treatment

I agree and consent to participate in mental/behavioral health care services provided by Collaborative Psychiatric Services. This includes, but is not limited to, treatment planning, medication management, and psychotherapy. I assert that I have discussed my goals, and time frame with my provider. I understand that the above may be modified or altered, as treatment progresses. I understand that I have the right to refuse treatment or terminate my treatment should I choose. I also understand that Collaborative Psychiatric Services can terminate my care with a 30-day transitional period, with notice. I understand the risks, alternatives, and nature of the treatment being provided. I consent to work towards the goals established in my treatment plan. I further acknowledge that the office staff will need access to my chart for such things as insurance, prescriptions, etc. Any information requested by a third party must not be released without my specific written permission. It is without any coercion or pressure that I sign my name to this consent.

Patient Signature: _____

Witness: _____

Date: _____

Patient Registration Form

Office Policy

Patient Appointments: We require our patients to show up AT LEAST 10 minutes prior to their appointment. Being late for your appointment will result in losing your appointment. You will be charged with the missed appointment penalty. If possible, please call the office to notify us of your tardiness.

Patient Insurance: Your most current insurance card **MUST** always be on file. If your insurance plan changes, even if the Member ID is the same, we need to have a copy of the card, as required by law. We have no way of knowing your information has changed. All new patients are required to present their insurance as well as Photo ID at their first visit.

Patient Insurance Out of Network: If we do not participate with your insurance company, you will be charged for the full cost of the office visit. If your insurance plan offers you out of network benefits, we are happy to give you receipts or any documentation you may need in order to collect from them. If your insurance does not offer out-of-network benefits you are responsible for the full cost of the office visit.

Copays: All office copayments are expected to be paid on the date of service. Insurance regulations do not permit us to waive any copays, coinsurance, or deductible payments due based on your health insurance policy. We accept cash, checks, and all major credit cards. If your check is returned for nonsufficient funds (NSF), you will be charged the bank fee.

Insurance Claims: If your insurance denies payment because they had requested information from you, the subscriber, YOU must contact your insurance and resolve any discrepancies. This will allow our office to reprocess the claims. Failure to do so will result in the full cost of the office visit becoming patient responsibility.

Medication: Failure to maintain your regularly scheduled appointments can result in your medication not being prescribed/called in for a refill. It is critical for our patients to maintain appointments and follow through with their recommended care. If your medication requires a prior authorization, please be advised we need 2-3 weeks' notice prior to the expiration of your current authorization. Please check with your pharmacist for the expiration date of any medication(s) requiring prior authorization. All refill calls should be left in our refill mailbox. You can access this by following the options on our phone auto-attendant. Please give us 48 hours to tend to any prescription refills. Refills will not be called in on Saturdays and Sundays, as the office is closed!

Patient Registration Form

Office Policy continued

Medicare Participants: I am authorizing Medicare benefits to be made on my behalf of Collaborative Psychiatric Services, for any services provided to me. I also authorize any holder of my medical information to dispense to the Health Care Administration and its agents should any documentation/information be needed. *Applies only if you are a Medicare participant

Patient Payments: Payments are required to be made within 60 days of receiving the mailed statement. Failure to do so will result in your appointment and prescriptions being put on hold until payment is made in full.

Patient Responsibility: The portion of a medical bill that the patient is required to pay rather than their insurance provider. Examples include but are not limited to cash rates, patient copays, co-insurance, deductibles, out of pocket cost, out of network costs, cancelation or missed appointment fees, etc.

Understanding Your Insurance: It is your responsibility to know what your insurance coverage is. We do not determine your patient responsibility totals (examples: copays, co-insurance, deductibles, out of pocket cost, out of network costs). That comes directly from your insurance provider based off your contract with the insurance provider. If you have any discrepancy with your insurance coverage or cost, CONTACT YOUR INSURANCE.

By signing this form you are authorizing Collaborative Psychiatric Services to release to your insurance provider, any and all information for billing purposes and direct payment to the office. By signing you are also authorizing the office to release information concerning medical care regarding mental health, medication, and treatment plan, should your insurance request such information. You also agree to endorse over any checks paid to you, by your insurance company, that should have been paid directly to Collaborative Psychiatric Services.

Patient Signature: _____

Printed Name: _____

Date: _____

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Release for Communication with PCP/Behavioral Health Specialist

I understand that my patient records are protected under all applicable state laws governing health care information that pertains to mental health services. They are also protected under federal regulations governing confidentiality. I acknowledge that my records cannot be released without my written consent. I also understand that I may revoke this consent at any time, except to the extent that action has been taken on it. This release will automatically expire within twelve months from the date signed.

I authorize

_____

(Please Print Treating Clinician(s) Name)

_____ To release any applicable information to my PCP
_____ To release medication information ONLY to my PCP
_____ NOT to release any information to my PCP

PCP's Name & Contact Info:

_____

_____

_____

_____

_____ To release any applicable information to my Behavioral Health Specialist
_____ To release medication information ONLY to my Behavioral Health Specialist
_____ NOT to release any information to my Behavioral Health Specialist

Behavioral Health Specialist's Name & Contact Info:

_____

_____

_____

_____

Signature: _____

Patient Registration Form

Credit Card/HSA Authorization

This office now offers the option to keep a credit card or HAS card on file. Any patient responsibilities or cash rates will be charged at the date of service, or once the patient's insurance has distributed an explanation of payment to the account.

Please note it is the patient's responsibility to be aware of their balance should their card decline. It is also the patient's responsibility to notify the office with any change to your saved payment method.

Information is stored in our EHR software and ran through encrypted and secure third-party point of sale system.

If you are interested in keeping a payment method on file, please complete in its entirety, the credit card authorization form.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information				
Card Type:	☐ MasterCard	☐ VISA	☐ Discover	☐ AMEX
	☐ Other			
Cardholder Name (as shown on card):				
Card Number:				
Expiration Date (mm/yy):		CVV:		
Cardholder ZIP Code (from credit card billing address):				

I, (your name:)_____, authorize Collaborative Psychiatric Service to charge my credit card above for copayments and other patient responsibilities*. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Customer Signature Date

**** Patient Responsibility**: The portion of a medical bill that the patient is required to pay rather than their insurance provider. Examples include but are not limited to, cash rates, copays, co-insurance, deductibles, out of pocket cost, out of network costs, cancelation or missed appointment fees, etc.*