PATIENT REGISTRATION

PATIENT NAME_____**MALE**_____**FEMALE**____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

*** IF PATIENT IS UNDER 18 YEARS OF AGE PLEASE FILL OUT THIS ADDITIONAL INFORMATION:*

*MOTHER'S NAME:*_____*DAYTIME PHONE #* **(** **)**_____

*FATHER'S NAME:*_____*DAYTIME PHONE #* **(** **)**_____

TELEPHONE: HOME(**)**_____ **WORK(** **)**_____

CELLULAR (**)**_____**OTHER(** **)**_____

SOCIAL SECURITY NUMBER:_____**BIRTHDATE**_______________

EMERGENCY CONTACT_____**PHONE**_____**RELATIONSHIP:**_____

PRIMARY CARE PHYSICIAN_____**PHONE(** **)**_____

REFERRED TO OUR OFFICE BY_____**PHONE(** **)**_____

RESPONSIBLE PARTY INFORMATION
(INSURANCE POLICY HOLDER)

NAME_____**RELATIONSHIP TO PATIENT**_____

IF PATIENT IS A MINOR CHILD PLEASE INDICATE HOW YOU ARE RELATED: BIOLOGICAL MOTHER, BIOLOGICAL FATHER, ADOPTED MOTHER, ADOPTED FATHER, LEGAL GUARDIAN, GRANDPARENT

OTHER:_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

TELEPHONE: HOME(**)**_____ _____**WORK(** **)**_____

CELLULAR(**)**_____**OTHER(** **)**_____

SOCIAL SECURITY NUMBER_____**BIRTHDATE**_______________

EMPLOYER_____**PHONE(** **)**_____

PRIMARY INSURANCE COMPANY_____**PHONE(** **)**_____

POLICY ID#_____**GROUP#**_____

SECONDARY INSURANCE INFORMATION

POLICY HOLDER_____**BIRTHDATE**_____/_____/_____

RELATIONSHIP TO PATIENT_____**HOME PHONE(** **)**_____

SOCIAL SECURITY #_____**EMPLOYER**_____

SECONDARY INSURANCE COMPANY_____**PHONE(** **)**_____

POLICY ID#_____**GROUP#**_____

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS CLAIMS. I PERMIT A COPY OF THIS AUTHORIZATION TO BE USED IN PLACE OF THE ORIGINAL. THIS AUTHORIZATION MAY BE REVOKED BE EITHER ME OR MY INSURANCE COMPANY AT ANY TIME IN WRITING. I CERTIFY THAT THE INFORMATION I HAVE REPORTED WITH REGARD TO MY INSURANCE COVERAGE IS CORRECT.

DATE_____**SIGNATURE**_____

IF PATIENT IS A MINOR CHILD PLEASE INDICATE YOUR RELATIONSHIP TO THE PATIENT:_____

FINANCIAL POLICY

The following is a statement of our Financial Policy which we require you to read, initial A - I and sign prior to receiving any treatment from our providers.

(A)_____ Thank you for choosing us as your behavioral health care provider. Please understand that payment of your bill is considered a part of your treatment. Insurance is a contract between you and your insurance company. It is your responsibility to know your insurance policy benefits. We are not always a party to this contract. We will not become involved in disputes between you and your insurance regarding deductibles, co-payments, covered charges, secondary insurance or other matters regarding reimbursement.

Insurance and Fee Policy

(B)_____ As a courtesy, we will verify, pre-certify and submit your insurance claim to a primary and secondary insurance plan, **we will not submit to a third insurance**. Your benefits, costs and co-payments as they pertain to your treatment will be discussed with you. Please be aware that some, and perhaps all of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other insurance. Any amount that your insurance company will not be paying is due from you at the time services are rendered. We do not balance bill on insurance plans in which we are participating or contracted providers. You are responsible for providing this office with copies of your insurance card(s) or any changes with your insurance or coverage prior to being seen by one of our providers. Failure to do so may result in a denial of your claim making you financially responsible for your session(s).

(C)_____ If you do not have insurance, full payment is due at the time-of-service.

FULL PAYMENT IS DUE AT TIME OF SERVICE. IT IS NOT OUR POLICY TO BILL WE ACCEPT CASH, CHECK, VISA AND MASTERCARD

24-Hour Cancellation Policy

(D)_____ You will be charged for every scheduled appointment unless you cancel at least **24 hours** in advance. Late cancellation or no shows will be billed at the rate of $40.00. Insurance carriers will not pay for no shows or cancellation charges, those will be your responsibility.

Appointment Reminder

(E)_____ We will make a courtesy reminder call 48 hours prior to your scheduled appointment. Ultimately keeping scheduled appointments is your responsibility.

No-Show policy

(F)_____ Following the second No Show with any Comprehensive Psychiatric Associates provider a letter will be sent to the patient/family stating which appointments have been missed. Following the third No Show appointment the patient/family will receive a letter of Termination asking them to find another mental health provider. Comprehensive Psychiatric Associates, LLC will provide care on an urgent basis only through our walk in clinic for thirty days from the date on the letter terminating the patient relationship.

Returned Check Fee

(G)_____ There is a fee of $25.00 for any check returned unpaid by your bank. If your bank returns a check as unpaid, you will be placed on a cash or credit card only basis, as we will no longer accept checks from you.

Paperwork

(H)_____ There are times when you may need paperwork completed by one of our providers. There is a fee for filling out forms and reports. The fees vary according to the document(s) needed. Paperwork and forms can take up to 10 business days to be completed.

Divorce

(I)____ If you have been or are now involved in divorce, please understand that, legally, we are not a part of the divorce and are not bound to any divorce decree issued by a court of law. The person that presents themselves or a minor child for treatment is responsible for payment of the medical bill. If your divorce decree states that your ex-spouse is to pay any portion of the medical bills, then you must pay us at the time of service and then seek payment from your ex-spouse per the terms of your divorce decree. We encourage all legal guardians to be present at all appointments for minor children.

_____ _____

Signature of Patient or Responsible Party **Date**

CONSENT FOR TREATMENT

I hereby voluntarily consent to receive services, which may include assessment, and referral recommendations deemed necessary and advisable in the judgment of Comprehensive Psychiatric Associates. If the patient is a minor or otherwise incapable of providing consent, I hereby authorize and consent to the same services for him/her.

I understand that the information given to Comprehensive Psychiatric Associates will be kept confidential and will only be released when: a written consent is obtained, a medical emergency occurs, a court order or subpoena is received; information is required by the insurance company and/or managed care firm to process claims and manage treatment; or a patient represents a serious danger to himself/herself or others. I hereby hold harmless Comprehensive Psychiatric Associates for any loss, costs, and damages allegedly sustained by me or my ward because of the release of information under the circumstances listed above.

_____ _____

Signature of Patient or Responsible Party **Date**

_____ _____

Signature of Parent/Responsible Party WHO IS NOT LIVING WITH THE MINOR CHILD (patient) **Date**