Permian Psychiatry

Patient Registration

Date: _____ Acct#: _____ *(office use)*

Name: _____
Last First Middle

Address: _____
Street City State Zip

Age: _____ **Birthdate:** _____ **Social Security #:** _____ ☐ **M** ☐ **F**

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

E-mail: _____

What is the **PRIMARY** phone number for **reminders/messages?** _____

1 **Emergency Contact Information:**

In case of **Emergency**, notify? _____ **Phone:** _____

Relationship to patient: _____

2 **Financial Responsibility (*if different from patient*)** **NEED COPY OF DRIVER'S LICENSE FOR FINANCIALLY RESPONSIBLE PERSON**

Name: _____ SSN: _____ Date of Birth: _____

Address: _____ Driver's License #: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

3 **All Patients:**

In the event you default on your account balance, the account will be forwarded to a collection agency.

4

Primary Insurance	Secondary Insurance
Insurance Company: _____	Insurance Company: _____
Primary Insured: _____	Primary Insured: _____
Relation to Patient: _____	Relation to Patient: _____
DOB: _____ SSN# _____	DOB: _____ SSN# _____
Insurance ID#: _____	Insurance ID#: _____
Group/Account #: _____	Group/Account #: _____
Employer: _____	Employer: _____

5 **All Insurances:**

This office is required to keep your signature on file authorizing us to file claims on your behalf.

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OFFICE POLICIES

PATIENT FINANCIAL POLICY

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our Office Manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment\coinsurance or deductible amount at the time of appointment.

- In the event that your health plan determines a service to be "non-covered", you will be responsible for the complete charge. Any balance due will be collected at the time of service or upon receipt of a statement from our office.

- After our office has sent three statements for the balance or the balance is passed due more than 120 days, the person who is financially responsible for the patient will be turned over to R&R Collection Agency.

- Since most insurances require prior-notification of services that will be provided, it is your responsibility to **notify our staff of any changes regarding your insurance coverage along with your address and phone number 2 days prior to service**. You will be responsible for any balance incurred if you fail to provide us with the information required to file your claim.

- You will have 15 days to provide your insurance company any information they request (Ex. Coordination of Benefits or other insurance inquiries, etc.). If you fail to do so, you will be responsible for the balance on your account.

- Minors – **An adult must accompany any patient under the age of 18 or the appointment will be rescheduled.** No prescriptions will be given to minors.
  Due to a significant increase in patients, we ask that you bring only the child with an appointment. We apologize for any inconvenience.

- Prescriptions – ***Triplicate prescriptions (ADD/ADHD meds) expire in 21 days and cannot be called in. There will be a charge for all lost, expired, or stolen prescriptions. *Changes in prescription dosage or medication cannot be made over the phone.** You will need to make an appointment if you need refills. * If you need a partial refill before your next appointment, call the pharmacy to request a refill first. After making the request, notify our office as to why you need the refill. *Prescription refill requests made after 3p.m. are processed the next business day. *Prior authorization for medications takes 2-3 days. Please do not call the office repeatedly. We understand you need your prescriptions and we will contact you once we receive a response from the insurance company.

I HAVE READ AND UNDERSTAND THE ABOVE REFERENCED POLICIES OF THIS PRACTICE AND AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND AND AGREE THAT THIS PRACTICE MAY AMEND SUCH TERMS FROM TIME TO TIME.

_____ _____/_____/_____
Printed Name of Patient Date

_____ _____
Signature of Patient or Legal Representative Relation to Patient