PREMIER PSYCHIATRY – Psychiatric and Behavioral Health Services

PATIENT ACCT #: _____ PATIENT REGISTRATION FORM DATE: _____

PATIENT INFORMATION (Please write information about the patient here.)

Patient Name: Last	**First**	**MI**	**Sex**	**Birthdate**

Address	**City**	**Zip**	**Phone**

Email	**Marital Status**	**SS#**	**Referring Doctor**

Patient's Employer	**Occupation**	**Employment Status**	**Work Phone**

INSURANCE INFORMATION (Please write information about the patient's insurance here.)

Primary Insurance Company Name	**Secondary Insurance Company Name** (if applicable)
Insurance Company's Address	**Insurance Company's Address**
City **State** **Zip**	**City** **State** **Zip**
Insured's ID Number **Group Plan Number**	**Insured's ID Number** **Group Plan Number**

POLICY HOLDER INFORMATION (Complete the information below if the patient is NOT the POLICY HOLDER)

Primary Policyholder's Name **DOB**	**Secondary Policyholder's Name** **DOB**
Primary Policyholder's Address **SEX** ☐ Male ☐ Female	**Secondary Policyholder's Address** **SEX** ☐ Male ☐ Female
City **State** **Zip** **Telephone**	**City** **State** **Zip** **Telephone**
Employer's Name **Telephone**	**Employer's Name** **Telephone**
SS # **Relation to patient** ☐ ☐ _____ **Spouse** **Parent** **Other**	**SS #** **Relation to patient** ☐ ☐ _____ **Spouse** **Parent** **Other**
Employer Plan Coverage If CHAMPUS: ☐ Active ☐ Retired ☐ Deceased ☐ ☐ Yes No Branch of Service: _____	**Employer Plan Coverage** If CHAMPUS: ☐ Active ☐ Retired ☐ Deceased ☐ ☐ Yes No Branch of Service: _____

RESPONSIBLE PARTY INFORMATION Responsible party is: ☐ Patient ☐ Primary Policyholder ☐ Secondary Policyholder

(Please complete the information below if the person responsible for paying the bill is not the PATIENT or the POLICYHOLDER.)

Responsible Party's Name **Sex**	**DOB** **SS #**
Address	**City** **State** **Zip**
Telephone	**Relation to Patient**

Emergency Contact: _____Relation: _____ Phone: _____

Refuse to Release Emergency Contact: ☐ Signature: _____ Date: _____

X _____ Date: _____

SIGNED (Patient, or parent if under 18 years of age)

PREMIER PSYCHIATRY

Psychiatric and Behavioral Health Services

10745 165th Street
Orland Park, IL 60467
Phone 708-799-8384

Patient Name: _____ DOB: _____

Authorization for Medical Treatment:

I authorize the physician(s), Psychologist(s), therapist(s), nurse practitioners, their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Premier Psychiatry ("Facility"). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician(s) and the Facility will follow the instructions of my physician(s) in the provision on said care.

Statement of Responsibility:

I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, conservator, or insured for all charges not covered by the above assignments. Charges may include insurance deductibles, co-insurance, co-payments, or out-of-pocket expenses.

Notice of Privacy Practices:

I have been given the opportunity to review the Facility's Notice of Privacy Practices for Protected Health Information. I understand that the facility has the right to change the Notice of Privacy Practices at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Patient Rights & Responsibilities:

I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change the Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

Patient Paperwork/Forms:

Patients requesting paperwork to be filled out for FMLA, disability, etc. must become an established patient with a minimum of 3 to 4 visits before any documentation will be completed. If your insurance company requires documentation prior to the fourth visit, it is your responsibility to notify the insurance company of this office policy.

All paperwork/forms needing to be completed by the doctor will require a fee that must be paid prior to paperwork being completed. If your insurance company does not cover this charge, it is the responsibility of the patient.

Signature _____ Date _____
(patient or authorized representative)

Relationship/authority (if signed by authorized representative) _____

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Client's Consent to Exchange Information

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission. For more information about this and other rights, please see the applicable Notice of Privacy Practices.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider received the request. **This consent expires 12 months from the date of my signature below unless otherwise stated herein**.

Premier Psychiatry is authorized to release protected health information related to the evaluation and treatment of

_____ _____ / _____ / _____
(Patient Name) (Date of Birth – MM/DD/YYY)

PRIMARY CARE PHYSICIAN

☐ I give consent for information regarding my treatment to be shared as follows:
Name of PCP: _____ PCP Phone: _____
Address: _____

Name of Therapist: _____ Therapist Phone: _____
Address: _____

Parent/Spouse/Legal Guardian: _____ Phone: _____

☐ I **do not** wish to have information regarding my treatment with this practice released to my PCP, therapists, or family.

INSURANCE CLAIMS PAYMENT

I authorize the release of medical information or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purpose of verifying the services rendered and obtaining payment of the account. I understand that execution if this authorization waives my right of confidentiality as to the material pursuant to this authorization.

Disclosure may include the following verbal or written information: (check all that apply)

____ Facesheet	____ History & Physical	____ Laboratory/diagnostic testing results	____ School info
____ Discharge summary	____ Medication records	____ Behavioral health/psychological consult	____ psychological eval/testing results
____ ER record report	____ Psychiatric evaluation	____ Psychosocial assessment	____ Other:_____
____ Substance abuse treatment record		____ Summary of treatment records & contact dates	

____ I hereby refuse to give authorization for any release of information

My signature below represents that I have read and understand the terms and statements above.

X_____

(Signature of Patient, Parent, Guardian, or Authorized Representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e. Power of Attorney, Living Will, or Guardianship papers, etc.)

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CONSENT TO TREATMENT WITH PSYCHOTROPIC MEDICATION

1. My doctor has explained to me that I have a mental/emotional disorder for which he is recommending psychotropic medication treatment. In the doctor's opinion, no other treatment, by itself, would currently be as effective in helping my condition.

2. I understand that the doctor is prescribing the smallest amount of medicine which, in his or her opinion, will be of help to me at this time.

3. I have been informed and given written information concerning any precautions I should take regarding activities and diet while on this medication.

4. I have been informed concerning possible side effects from taking these medications.

5. If this prescription is for major tranquilizers or neuroleptics, this medication can, in some persons, result in physical disorder of abnormal movements of the tongue, face, and extremities called Tardive Dyskinesia. I understand that this disorder may be permanent. I have been informed that my doctor and nurse will watch for any sign of this disorder.

6. I have had all questions concerning my mental/emotional disorder, and the psychotropic medications recommended for me, answered to my satisfaction at this time. I know that I can speak with my doctor or nurse concerning any other questions which I may have concerning these in the future.

7. I agree to:
   A. Take the medication prescribed for me in the manner recommended by my doctor.
   B. Follow the doctor's recommendation for any laboratory test which may be needed because of taking this medication.
   C. Report any possible side effects, or unexpected reactions, as soon as possible, to my doctor, nurse, client services manager or other staff.
   D. Tell my doctor, nurse, client services manager, if, at any time I want to stop taking these medications, and the reason of my choice.

_____ _____

Patient, Parent or guardian Signature Date

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Fax 708-799-1305

Consent for Treatment- Non-Prescribing Provider

Patient Name: _____ DOB: _____

I have discussed the need for treatment, alternative methods of treatment and the possible consequence of the decided on treatment which includes the following methods and interventions:

For the purpose of…
_____ Stabilization
_____ Decrease and relieve symptomatology
_____ Improve
_____ Medication management and Psychotic stabilization
_____ Behavior modification and cognitive restructuring

While I expect benefits from this treatment, I fully understand and accept that because of factors beyond my control, such benefits and desired outcomes cannot be guaranteed.

I understand that regular attendance and participation will produce the maximum possible benefits but I or we am/are free to discontinue treatment at any time in accordance with the policies of the office.

I am not aware of any reason why I/we/he/she should not proceed with treatment and I/we/he/she agree to participate fully and voluntarily.

Signature of Patient/Guardian _____ Date _____

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It has always been the policy of Premier Psychiatry to charge for appointments where the client has either missed their session or gave less than 48 hours notification that they needed to cancel. Our doctors and therapists have only a limited number of sessions available during any given week and misses and late cancellations prevent them from fully using this valuable resource.

Due to our heavy volume and long waiting list for appointments, there will be a charge of $45.00 for any missed or last minute cancellations on appointments. We will not bill your insurance company, we will bill you, the patient. We request a 48-hour notice for rescheduling any appointments.

Also, if you have not called us to reschedule your appointment, we can no longer call in your prescriptions.

Keeping your appointment is your best way to move towards health. A missed appointment not only prevents you from getting the care that you deserve, but it also prevents someone else from using that appointment time.

By acknowledging this letter with your signature, shows that you have read our terms: And as always, we are here to better serve our clients.

Patient's Signature: _____
[parent or guardian if minor]

Date: _____

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES

Your Rights

• You have the right to receive considerate, respectful and compassionate care in a safe setting regardless of your age, gender, race, national origin, religion, sexual orientation, gender identity or disabilities.
• You have the right to receive care in a safe environment free from all forms of abuse, neglect, or mistreatment.
• You have the right to make decisions about your care, also known as informed consent.
• You have the right to be told the names of your doctors, nurses, and all health care team members directing and/or providing your care.
• You have the right to be told by your doctor about your diagnosis and possible prognosis, the benefits and risks of treatment, and the expected outcome of treatment, including unexpected outcomes.
• You can expect full consideration of your privacy and confidentiality in care discussions, exams, and treatments.
• You and your family, with your permission, have the right to participate in decisions about your care, your treatment, and services provided.
• You have the right to know the name of the medication you are taking, why you are taking it, and what its possible side effects might be.
• You can expect that all communication and records about your care are confidential, unless disclosure is permitted by law. You have the right to see or get a copy of your medical records. You have the right to request a list of people to whom your personal health information was disclosed.
• You have the right to receive an explanation of the fees for which you are responsible.
• You have the right to voice your concerns about the care you receive. If you have a problem or complaint, you may talk with your doctor, therapist, or manager.

Your Responsibilities

• You are expected to provide complete and accurate information, including your full name, address, home telephone number, date of birth, Social Security number, insurance carrier and employer when it is required.
• You are expected to provide complete and accurate information about your health and medical history, including present condition, past illnesses, hospital stays, medicines, vitamins, herbal products, and any other matters that pertain to your health, including perceived safety risks.
• You are expected to ask questions when you do not understand information or instructions. If you believe you cannot follow through with your treatment plan, you are responsible for telling your doctor. You are responsible for outcomes if you do not follow the care, treatment, and service plan.
• You are expected to treat all staff and other patients with courtesy and respect; abide by all safety regulations; and be mindful of noise levels and privacy.
• You are expected to provide complete and accurate information about your health insurance coverage and to pay your bills in a timely manner.
• You have the responsibility to keep appointments, be on time, and call your health care provider if you cannot keep your appointments

Patient Name: _____

Signature: _____

Date: _____