Patient Information

Patient Name (Last, First, Middle Initial): _____

Preferred Name: _____

SSN: _____-____-_____Sex:_____ Date of Birth(mm/dd/yyyy):_____

Home Address: _____

_____

Billing Address: _____

_____

PLEASE CHECK THE BOX NEXT TO YOUR PREFERRED NUMBER:

Home Phone: _____ ☐

Cell/Other Phone:_____ ☐

A cell phone number must be indicated if you would like to be considered for telemedicine visits

Do you consent to receive automated appointment reminders via phone, email, or text message? ☐ Yes ☐ No

Do you consent to receive secure text messages from your providers and/or office staff: ☐ Yes ☐ No

Email Address:_____

emails are sent when you schedule your appointment and sometimes include electronic intake forms

Referred by/PCP:_____

Are you seeking treatment for medication management, therapy, or both?

_____

Responsible Party:_____

Relation to Patient:_____

Emergency Contact Name:_____

Emergency Contact Phone:_____

Relation to Patient: _____

Releasing Information

Check this box to allow CPW to send your records to your referring physician's office.

CPW may also speak to the following person about my care & appointments:

Please note: By listing someone in this field, you are giving them permission to schedule and cancel appointments on your behalf, as well as discuss care.

Name of Person:_____ Relationship:_____

Contact Phone:_____

_____ _____

Name/Signature of Patient or Parent/Guardian Date

If you are filling out electronically, please put your full name above and check box below to serve as your electronic signature

e- signature consent: ☐

Medications

Pharmacy Name:_____
Pharmacy Location:_____
Pharmacy Phone:_____

Drug Allergies:_____

_____

Current Medications (medical, psychiatric, and over the counter):

Name	Dose	Time	Prescribing Provider

List any additional medications below:

_____
_____
_____

Primary Insurance Information

Company:_____

Subscriber/Member ID:_____Group#:_____

Policy Holder Information:

Name:_____

SSN: ____-____-_____ Date of Birth:_____

Address:_____

_____

Employer:_____

Relation to Patient:_____

Secondary Insurance Information

☐ Check here if not applicable

Company:_____

Subscriber/Member ID:_____Group#:_____

Policy Holder Information:

Name:_____

SSN: ____-____-_____ Date of Birth:_____

Address:_____

_____

Employer:_____

Relation to Patient:_____

Clinic Policies:

Late and No Show Policy for Psychiatrist and Nurse Practitioners:

We will always work to accommodate late patients as often as possible, however we cannot compromise our patient care. If a patient is more than 10 minutes late, they will be given the choice to take an open appointment later that day (if available) or reschedule the appointment.

We ask that our patients call 24 hours in advance to cancel their appointment. With giving our clinic this courtesy, we will be able to offer the appointment to other patients needing medical care.

If patients fail to come to their appointment and fail to call to cancel 24 hours in advance, there will be a charge of **$50.00** for a missed initial appointment and **$25.00** for a follow up appointment. This balance will be the responsibility of the patient and will have to be satisfied before the patient's next appointment. A **$50.00** fee will apply for the 2nd and 3rd missed follow-up appointment.

Also, if two initial appointments, or three follow up appointments are missed, a termination of services may occur.

Please understand this policy is to honor both our patients' and providers' time in allowing providers to stay on schedule and to keep wait times at a minimum.

Payment Policy:

With CPW being a specialty clinic, it is customary to collect payment prior to services rendered. In order to be in compliance with our contracted insurance companies, payment from our clients should take place **before** the scheduled appointment. Such payments may include copays, deductible/coinsurance amounts, and any outstanding fees that the patient might have.

We will work to be as accommodating as possible and will continue to provide the best care to our patients.

Thank you for your understanding,

William C. Kindrick
CPW Medical Director

I have read and agree to the above clinic policies:

Name/ Signature:_____ Date:_____

If you are filling out electronically, please put your full name above and check box below to serve as your electronic signature*

e- signature consent: ☐

Consent for Treatment

We are completely independent in providing you with clinical services, and we alone are fully responsible for those services. Our professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian, or conservator) consents to, and authorizes services by, Center for Psychiatric Wellness, PLLC. These services may include psychotherapy, medication, therapy, laboratory tests, diagnostic procedures, and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

_____ _____

Name/Signature of Patient Date Signed

_____ _____

Name/Signature of Parent, Legal Guardian, or Conservator Date Signed

_____ _____

Name/Signature of Witness (if appropriate) Date Signed

If you are filling out electronically, please put your full name above and check box below to serve as your electronic signature

e- signature consent: ☐