

Patient Information

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

Preferred Name: _____

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

Home Address: _____

Billing Address: _____

PLEASE CIRCLE 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? Y N

Do you consent to receive secure text messages from your providers and/or office staff: Y N

Email Address: _____

Employer: _____

Responsible Party (if patient is a minor): _____

Relation to Patient & Date of Birth: _____

Additional Responsible Party (Example: Other parent): _____

Relation to Patient & Date of Birth: _____

Emergency Contact Name: _____

Emergency Contact Phone & Relation to Patient: _____

Who referred you to us?: _____

Who is your primary care physician?: _____

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

What condition are you seeking treatment for? _____

Please note: Records of ADHD testing & diagnosis will be REQUIRED prior to scheduling an appointment if you are seeking treatment of ADHD

Please select the service(s) you are requesting (Select all that apply)

- Medication Management** – provided by a psychiatrist or psychiatric nurse practitioner to determine if medication is needed and to manage those medications
- Therapy** – provided by licensed counselors as talk therapy, play therapy, or EMDR
- TMS** – Transcranial Magnetic Stimulation

Please note that Coordination of Benefits **MUST** be established if you have more than one insurance coverage. This is **REQUIRED** per your contract with your plan. We are also required per our contract to file claims to the correct plan. If you need more clarification, please let us know.

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 prior to scheduling another 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 and independent 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,

Rachel Fiori
CPW Medical Director

I have read and agree to the above clinic policies:

Signature: _____ Date: _____

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.

Signature of Patient

Date Signed

Signature of Parent, Legal Guardian, or Conservator

Date Signed

Signature of Witness (if appropriate)

Date Signed

PATIENT AUTHORIZATION FORM

Authorization to Release Information

If you wish to have your medical information discussed with anyone other than yourself, we must have consent from you to remain compliant with HIPAA regulations. This information includes your diagnosis, test results, appointment dates (including scheduling/canceling appointments on your behalf), financial information and information regarding your medications such as being able to request or to pick up refills. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

THIS DOES NOT APPLY TO RELEASE OF FULL MEDICAL RECORDS

I authorize Center for Psychiatric Wellness to discuss my medical information with the following individuals:

1. **Name:** _____

Relation to Patient: _____ **Phone:** _____

2. **Name:** _____

Relation to Patient: _____ **Phone:** _____

3. **Name:** _____

Relation to Patient: _____ **Phone:** _____

4. **Name:** _____

Relation to Patient: _____ **Phone:** _____

Patient Name (PLEASE PRINT)

Date Signed

Patient/Guardian Signature