Milwaukee Psychiatrists &
Psychologists Chartered

Marie Ferber, MD * Brian Fidlin, PsyD * Eric Kanter, MD * Margaret Regner, PhD * Gary Schnell, MD
Melvin Soo Hoo, MD * Tracey Latza, PsyD * David Wandschneider, PhD * John Wean, MD * Randall Zblewski, MD

12760 W North Ave, Bldg A., Brookfield, WI 53005-4628 * Office: (262) 439-5500 * FAX: (866)439-5221
www.milwaukeepsychiatric.com

PATIENT INFORMATION:

Name: _____ Date of Birth: ____/____/____
Last First Middle Initial

Address: _____
Street City State Zip Code

Home: (____)_____ Work: (____)_____ Cell: (____)_____
OK to Leave Message?: Y/N Y/N Y/N

Sex: Male _____ Female_____ Email Address: _____

SS#:_____ Marital Status: _____ Employer: _____

Emergency Contact: _____ Phone: (____)_____
Name Relationship

REFERRING/PERSONAL PHYSICIAN:_____ Phone: (____)_____

Address: _____
Street City State Zip Code

GUARANTOR INFORMATION (Person responsible for payment):

Name:_____ Relationship to Patient: _____

Address: _____
Street City State Zip Code

Home: (____)_____ Work: (____)_____ Cell: (____)_____

SS#: _____

For Patients Not Using Insurance:

I, _____ agree to be responsible for all fees for services provided for me (or my child, if guarantor) by MPPC. I do not want MPPC to file any claims with any insurance company for services received.

PLEASE SEE BACK SIDE OF PAGE

INSURANCE INFORMATION - PRIMARY

Insurance Name: _____ Insurance Phone: (____)_____

Insured's Name: _____ Relationship: _____ Employer: _____

Insured's Address: _____
Street City State Zip Code

Insured's Date of Birth: _____/_____/_____ Insured's SS#: _____

ID/Policy #: _____ Group #: _____ Effective Date: ____/____/____

INSURANCE INFORMATION - SECONDARY

Insurance Name: _____ Insurance Phone: (____)_____

Insured's Name: _____ Relationship: _____ Employer: _____

Insured's Address: _____
Street City State Zip Code

Insured's Date of Birth: _____/_____/_____ Insured's SS#: _____

ID/Policy #: _____ Group #: _____ Effective Date: ____/____/____

CANCELLATION & MISSED APPOINTMENT POLICY:
Notification is required 24 hours prior to the appointment. Lack of notification will result in an **$85 - $110 missed appointment fee, depending on time of the scheduled appointment**. This charge will not be covered by insurance and will be the responsibility of the patient or guarantor. If you cancel your appointment with less than 24 hour notice and/or miss 3 appointments, you may be subject to discharge fron the physician's practice. *Please note, leaving a voicemail is an acceptable form of notification.*

MILWAUKEE PSYCHIATRIC PHYSICIANS CHARTERED IS NOT GUARANTEEING THIS PHYSICIAN IS IN YOUR INSURANCE PLAN. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

Signature: _____ Date: ____/____/____
(Patient, Parent or Guardian)

My signature above indicates that I have provided accurate information to the best of my knowledge.

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CREDIT CARD INFORMATION

It is our policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant and confidential manner.

We require that insurance co-payments be paid at the time of your visit. If a patient is not able to pay their co-payment at the time of their visit with cash or check, we will use the credit card on file to process the payment for them.

If a patient becomes more than 90 days overdue, with any balance, we will process the payment for them using their credit card information or they may set up a monthly installment plan. Please contact our billing office at 262-439-5500 option 3 for more information.

MILWAUKEE PSYCHIATRISTS & PSYCHOLOGISTS CHARTERED DOES NOT ACCEPT PATIENTS WITHOUT A VALID CREDIT CARD ON FILE.

Patient Name: _____

Cardholder Name: _____

Cardholder Zip Code: _____

Credit Card Type: VISA_____ MasterCard_____ Discover_____

Card #: _____

Expiration Date: _____Month/_____Year V-Code:_____
(3 or 4 digit security code)

I authorize MPPC to run balances on this credit card instead of receiving monthly statements: Y N
Please circle

Signature of Card Holder:_____Date:_____

*****WE DO NOT ACCEPT AMERICAN EXPRESS*****

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AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

I hereby authorize Milwaukee Psychiatric Physicians Chartered (MPPC) for evaluation and treatment of myself or my child. I authorize MPPC to provide my insurance company or their representatives with information concerning my (or my dependent's) illness, injury and/or treatment necessary for completion of claims for insurance benefits.

PAYMENT POLICIES

Payment is expected at the time of service. If you have insurance coverage, we will submit charges to the insurance on your behalf, but co-pays are to be paid at the time services are rendered. Services performed outside of the office, including, but not limited to, court appearances, depositions, school visits, extended telephonic/electronic communication, etc., cannot be billed to insurance and therefore any fees related to these services will be your responsibility. Fees for professional services are based on our own experience and not on payment schedules promoted by insurance companies as usual and customary. MILWAUKEE PSYCHIATRIC PHYSICIANS CHARTERED IS NOT GUARANTEEING THAT YOUR PROVIDER IS IN YOUR INSURANCE PLAN. PLEASE CHECK WITH YOUR INSURANCE COMPANY.

In divorce situations, the parent that brings the child to the appointment is responsible for payment of charges including co-payments, *regardless of divorce decree*. If payment issues exist, they must be resolved between the parents.

I understand that I am responsible for the portion of fees not paid by insurance. If the account becomes delinquent I understand that it may be sent to collections and interest may be charged.

PRIVACY, RIGHTS AND RESPONSIBILITIES

I received the Notice of Privacy Practices. It explains how health information is handled.
Medical records may be shared with health providers and insurance companies for treatment, payment and health care operations, with written consent of the patient or guardian.

I am legally able to consent and give my permission for treatment. My signature below indicates that I have provided accurate information to the best of my knowledge and I understand and agree to the provisions above.

Patient's Name (Printed):_____

Signature: _____

Relationship to patient: _____ Date: _____