RESTORE PSYCHIATRY WELLNESS

PHONE: 503-468-5943 FAX: 940 666 3689

Date _____ Appt Date _____

Name; Last _____ First _____
Middle_____

DOB ____-_____-_____ Age _____

If a minor, name of parent / legal guardian: _____

Gender: Male Female Marital Status: S M D W Other

Address: _____

City _____ State _____ Zip code _____

Cell # _____ Home # _____

Email address _____

Employer _____ Work # _____

Contact person incase of an emergency: _____

Phone # _____ Relation to patient: _____

Insurance company _____ Policy holder's name _____

Relationship _____ DOB of insured _____ SSN of insured _____

Insured's address _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to my provider. I understand that I am financially responsible for my balance. I also authorize my provider and/or insurance company to release any information required to process my claims, Initial _____

Pharmacy name _____ Phone # _____

Whom may we thank for referring you? _____

Signature _____ Date _____

Office Use Only : Copay / Deductible : _____

Met deductible _____ Out of Network benefits _____

Reason for your visit today?

_____

_____

Medical History :

Medication _Allergies:

_____

_____

Current medications, including vitamins / supplements/ herbs

_____

_____

List any psychiatric or medical hospitalizations

_____

_____

List any psychiatric outpatient treatment locations

_____

_____

Social History

Do you smoke? YES NO If yes, how much per day? _____

Do you drink alcohol? YES NO If yes, how much per day? _____

Do you use recreational drugs? _____

Highest level of education completed? _____

Do you have a history of abuse? _____

DO YOU HAVE OR HAVE EXPERIENCED ANY OF THE FOLLOWING? IF SO< PLEASE CHECK BOX.

	High blood pressure		Blurred vision		Weight loss
	Diabetes		Loss of vision		Nausea/vomiting
	High cholesterol		Chest pain		Urine problems
	Stroke		Shortness of breath		Back Pain
	Asthma		Blood in sputum		Joint pain
	Low/high thyroid		Constipation		Skin rash
	Cancer		Diarrhea		Mood disturbances
	Acid reflux		Blood in stool		Depression
	Headache		Memory loss		Insomnia
	Fatigue		Anxious/Nervous		Hot flashes

Do/Did you or any of your family members have any of the following?

Bipolar disorder YES NO Relation _____

Depression YES NO Relation _____

Schizophrenia YES NO Relation _____

Attempted suicide YES NO Relation _____

Substance abuse YES NO Relation _____

INDIVDUAL PATIENT AUTHORIZATION: AUTHORIZATION TO USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION FOR A SPECIAL PURPOSE/DISCLOSURE OR USE OF HEALTH INFORMATION.

You have certain rights regarding your protected health information under the Health Insurance Portability and Accountability Act (HIPAA)

Please initial the types of information you authorize us to disclose:

_____ My provider may release any medical information needed to determine payment for my services. My provider may release protected information to HIPAA covered entities on my behalf including health plans, providers, health care claim clearing houses, and others. I understand that without this authorization, my provider cannot file claims to my insurance, and I will personally pay ion full at the time of the service for all medical services.

In addition, please initial any or all the following uses/authorizations:

_____ My provider and his or her staff may leave voicemails and messages on my phone for appointment reminders or general medical information.

_____ My provider and his/her staff may communicate verbally with :_____ (for example family or someone who may answer your phone) regarding appointments, test results, and/or general medication. **Please note that if you need us to disclose or receive medical information from other parties (other medical providers, hospitals, attorneys, etc.), you must make a separate request in writing. Our office can provide a request form for you, there may be financial charges associated with these requests.

Initial the specific types of information you authorize to be disclosed to the persons listed above:

_____ ALL INFORMATION PRESENT IN THE MEDICAL CHART

OR

_____ ALL MEDICAL INFORMATION EXCLUDING PSYCHIATRY AND PSYCHOTHERAPY PROGRESS NOTES

_____ PSYCHIATRY AND PSYCHOTHERAPY PROGRESS NOTES ONLY

_____ ONLY THE HEALTH INFORMATION DETAILED HERE _____

I understand, Please initial _____

- This authorization can be revoked at any time by written notice to my provider
- Any revocation will become effective the date it is received by my provider
- This authorization does not limit the treatments available to me, it only affects the use of my medical information
- Redisclosure of my health information by a HIPAA covered entity receiving the information may occur

Patient or patient representative confirming this authorization:
Printed patient/representative name: _____
Printed patient / representative signature _____Date _____
If representative is signing for patient, list relationship _____

I have read and received a copy of the privacy policies of my provider .
Patient/ Rep's signature _____ Date _____

The providers at North Texas Psychiatry and Psychotherapy appreciate the confidence you have shown in choosing them to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part, The responsibility obligates you to ensure payment in full for your provider's fees. As a courtesy, your provider will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any deductible and copayment as determined by your contract with your insurance carrier. These payments are expected at the time of service. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to my providers for providing services to me or the previously named patient, I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to my provider, including the full and entire amount of the bill incurred by me or the previously named patient.

Patient signature _____ Date _____
Guarantor signature _____ Date _____

If guarantor is not the patient

COPAY POLICY

Some insurance carriers require the patients to pay deductibles, copays, and/or co insurance for services rendered. It is expected and appreciated for the patient to pay at the time the visit is rendered, at EACH VISIT.

I am aware that I am responsible for deductibles, co payments, and/or co insurance at the time of service.

Patient/ Guarantor signature _____ DATE _____

SELF PAY

I do not have health insurance and will be responsible for services rendered by my provider. I agree to pay the full and entire amount , as determined by my provider, for treatment given to me or the above mentioned patient at each visit.

Patient/ Guarantor signature _____ DATE _____

CANCELLATION/ NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations at work, school or family. However, we urge you to provide 24 hours advance notice when cancelling your appointment; anything less will be considered a no-show.

There is a no show fee of $20 for the first missed appointment, $40 for the second, and $75 for the third and any additional missed appointments(these amounts may vary by individual provider). If you fail to show for two consecutive appointments, fail to show for a total of three appointments, or routinely cancel appointments, you may be discharged from care.

I have read and understand the above information, and I agree to the terms described.

Patient/ Guarantor signature _____ Date _____