

**Plaza West Psychiatrists**  
Updated Registration Form

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Marital Status \_\_\_\_\_

Gender M / F

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Reminder Call Preference H / C

Email Address: \_\_\_\_\_ Would you like access to our patient portal Y / N

Race \_\_\_\_\_ Ethnicity \_\_\_\_\_ Preferred Language \_\_\_\_\_ Religion \_\_\_\_\_

Employer \_\_\_\_\_ If Full Time Student, School \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

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**Guarantor/Parent/Spouse/Other Relationship to Patient Information**

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

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**Insurance Information**

Please present all insurance cards to receptionist

Primary Insurance \_\_\_\_\_ Policy/ID # \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Relationship to Patient \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance \_\_\_\_\_ Policy/ID# \_\_\_\_\_ Effective Date \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Subscriber's Relationship to Patient \_\_\_\_\_

Subscriber's Social Security Number \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Authorize and Release**

I certify the above information is correct to the best of my knowledge. I authorize the provider to release any information including the diagnosis and the records for any treatment rendered to me or my child to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the providers office insurance benefits otherwise payable to me. I understand my insurance carrier may pay less than the actual billed services and that I am ultimately responsible for any unpaid balances. I understand and agree that this office may leave messages for me on the phone numbers provided by myself/guardian.

**Signature of Patient/Parent or Guardian** \_\_\_\_\_

# **PLAZA WEST PSYCHIATRISTS**

**2222 S 16<sup>th</sup> St, Suite 410, Lincoln, NE 68502, Ph: 402-474-1511, Fax: 402-474-1611**

Jose Gary Nadala, MD  
Sanat K Roy, MD  
Kirk L. Brown, D. Min., LIMHP  
Bambi Reckling, MS, LIPC

Lisa Young, MSN, APRN, BC  
Wendy Hoins, MSN, APRN, BC  
Nathan Warner, MSN, APRN, BC

## **Important Patient Information**

Thank you for choosing Plaza West Psychiatrists. As a healthcare provider our goal is to improve the quality of life by providing exceptional mental health care. Upon the initial visit, you will meet with and discuss with your provider your history, reasons for initiating care and establishing a treatment plan best suited to your needs. Patients are asked to be as open as possible with their provider. We can better serve your health care needs if you are familiar with the following policies and procedures.

### **Office Hours & Appointments**

Our office is open Monday through Friday from 8:00 a.m. to 6:00 p.m. Our telephone hours are 9:00 a.m. to 6:00 p.m. After hour calls are handled by our answering service, who do have the capability of reaching provider in the event of an emergency. Follow up appointments should be made prior to leaving the office. The frequency of the appointments is determined by your provider. Typically, Follow up Appointments for Medication Management are 15 minutes and Therapy Appointments 1 Hour. Appointments may also be scheduled by calling 402-474-1511. It is the patient responsibility to arrive on time for their appointment, if you are more than five minutes late you will be asked to reschedule. Appointments should be canceled no later than 24 hours prior to the scheduled appointment time. Patients no showing three or more appointments are subject to termination. Please note in the event of inclement weather Plaza West Psychiatrists follows the closure procedure of Southeast Community College.

### **Insurance and Financial Responsibility**

It is up to you as a patient to provide us with current Insurance Information, as a courtesy we will bill medical claims to your insurance company. Monthly billing statements are generated and payment is due 30 days from receipt. Payment arrangements can be made on balances by calling our Billing Specialist at 402-474-1511 ext 3. All Copayments are due at time of service. Patients without insurance will be asked for payment in full prior to the scheduled appointment. If your account balance is unpaid and past due we will make three attempts at contacting you, if you fail to respond your account will be referred to a collection agency. Any balances listed at a collection agency must be paid in full prior to scheduling another appointment at our office.

### **Prescription Refill Requests**

Medication refills requiring a written script should be requested during your appointment or may be requested by calling us at 402-474-1511. For all other medications, please call your pharmacy to request. Please allow us 24 hours to fulfill your refill request. Please note medications sometimes require a prior authorization from your insurance company, once we have received the proper paperwork from your pharmacy we will initiate the prior authorization which may take up to **3-4 days**. Patients who have failed to make or have missed appointments, run the risk of refill requests being denied. Please call our office to report a medication side effect or any worsening conditions. If you encounter a true medical emergency, call 911.

I have read and understand all above policies

Signature of Patient/Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

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**Authorization for Disclosure of Health Information**

We need a form completed for each person you would like us to disclose your information to

**Medicaid Patients** must complete this form for your Primary Care Provider, if you do not have a Primary Care Provider please write None and complete

Patient Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Consent \_\_\_\_\_

Hereby Authorize: Plaza West Psychiatrists

**To Receive \_\_\_\_\_ To Release \_\_\_\_\_ Protected Health Information To/From:**

\_\_\_\_\_  
Name of Health Care Provider/Agency/Plan/Other

\_\_\_\_\_  
Address City, State, Zip Code Phone Number Fax Number

**INFORMATION TO BE DISCLOSED:** (please check all that apply)

- Entire Record
- Psychological Evaluation
- History & Physical Examination
- Other (Specify): \_\_\_\_\_
- Psychiatric Evaluation
- Consultations
- Termination Summary
- Laboratory Reports
- Prescriptions
- Treatment Plan
- Substance Use Assessment

**REASON FOR DISCLOSURE:** (please check all that apply)

- Request of Patient
- Obtaining past treatment records
- Other (Specify) \_\_\_\_\_
- Collaboration of Care
- Changing Providers
- Legal Purposes
- Consultation and/or Treatment

I understand that I may revoke this authorization at any time in writing or it will automatically expire 12 months from the date signed. By signing this Authorization, I acknowledge that the information to be released may include material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Plaza West Psychiatrists from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (fax) copy shall have the same effect and authority as the original copy.

**Signature of Patient/Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

**Witness** \_\_\_\_\_