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

How would you like to receive Appointment Reminders? Phone Call / Text / Email

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____

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____________________

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_____/_____/____

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 16th 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
Nathan Warner, MSN, APRN, BC
Eileen 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____________________

Revised 10-2018

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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
___ Psychiatric Evaluation
___ Laboratory Reports
___ Treatment Plan
___ Psychological Evaluation
___ Consultations
___ Prescriptions
___ Substance Use Assessment
___ History & Physical Examination
___ Termination Summary
___ Other (Specify):____

REASON FOR DISCLOSURE: (please check all that apply)

___Request of Patient
___Collaboration of Care
___ Legal Purposes
___Consultation and/or Treatment
___ Obtaining past treatment records
___Changing Providers
___Other (Specify) ____

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____

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Informed Consent to Treatment

This form is to document that I, __________________________________, **(your name)** give my permission and consent to **Plaza West Psychiatrists** to provide mental health services to me or give my consent for the minor or person under my legal guardianship __________________________**(patient name).**

While I expect benefits from this treatment I fully understand that because of factors beyond our control or other factors, such as benefits and particular outcomes cannot be guaranteed.

I understand that because of the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changed which could be distressing.

I understand that this provider is not providing an emergency service and I have been informed of whom to call upon in emergency or during weekend and evening hours.

I understand that regular attendance will produce the maximum benefits but that I am free to discontinue treatment at any time. If I decide to do so I will notify the provider at least two weeks in advance so that effective planning or continued care can be implemented.

I understand that conversations with the provider will almost always be confidential. I further understand that the provider by law, must report actual or suspected child or elder abuse to the appropriate authorities. In addition, the provider has a legal responsibility to protect anyone I may threaten with violence, harmful or dangerous actions (including those to myself) and may break the confidentiality of our communications if such a situation arises. I understand that the provider will make reasonable efforts to resolve these situations before breaking confidentiality.

I understand that I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my insurance.

I know of no reasons I should not undertake this therapy and I agree to participate fully and voluntarily.

Signature of Patient/Parent or Guardian____Date____________________