Advanced Psychiatry Patient Registration

Phone: 817-873-0590 ***Fax: 817-873-0591***

Date:_____

Acct.#:_____

Patient information

Patient Name:_____
Last First Middle Initial Preferred Name (nickname)
SS#:_____-_____-_____ Gender: ☐ F ☐ M Date of Birth:_____/_____/_____ Age:_____

Home Address:_____Apartment #_____

_____
City State Zip Code
Primary Phone: (___)_____type:_____

Alternate number: (____)_____type:_____

Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
Race: ☐ White ☐ Black ☐ Hispanic ☐ Native American ☐ Other: _____
Ethnicity: _____

Employed: ☐ Yes ☐ No Student: ☐ Yes ☐ No
Employer: _____ Occupation:_____

Address:_____

Wk. Phone: (____)_____x_____
May we contact you by phone for appointment reminders? Primary phone: ☐ Yes ☐ No Work: ☐ Yes ☐ No

Additional Contact Information

Emergency Contact: _____

Phone: (____)_____ Relationship to Patient:_____

Referral Source:_____

Specialty:_____ Phone: (____)_____

Address:_____

Spouse's Name:_____ Spouse's Date of Birth:_____/_____/_____
Last First
Spouse's Employer:_____

Spouse's Work Phone: (____)_____x_____ Spouse's SS#: _____-_____-_____

Pharmacy Information

For your convenience we would like to have at least one pharmacy on file:

Local Pharmacy Name: _____
Phone Number:_____
Address: _____
_____
_____

Local Pharmacy Name: _____
Phone Number:_____
Address: _____
_____
_____
Name of Mail Order Company (if applicable):
_____

Advanced Psychiatry participates in the ePrescribe program which allows us to electronically prescribe you medication and controlled substances. It allows us to check your formulary and benefits, fill status, and medication history transaction.

Understanding all of the above, I hereby provide informed consent to Advanced Psychiatry to enroll me in this ePrescribe program.

Signature of Patient or Guardian:_____ Date:_____

****

Is patient under the age of 18? ☐ **Yes** ☐ **No**

IF YES, PARENT / GUARDIAN MUST FILL OUT
IF NO, PLEASE STOP HERE AND SIGN BELOW

Parent Name:_____ Date of Birth: _____/_____/_____
Last First
Address: _____SS#: _____-_____-_____

City: _____ State: _____ Zip_____ Home Phone: (____)_____

Employer: _____ Work Phone:

(____)_____x_____ Relationship to patient: _____

_____ _____
Signature of Patient/Parent/Guardian **Date**

INSURANCE INFORMATION

Primary	***Secondary (if applicable)***
Carrier Name: _____	Carrier Name: _____
ID#: _____	ID#: _____
Group Name / Number: _____	Group Name / Number: _____
Policy #: _____	Policy #: _____
Ins. Co. Phone #: (____)_____	Ins. Co. Phone #: (____)_____
Insured Party Information (**If other than Patient**):	Insured Party Information (**If other than Patient**):
Name: _____	Name: _____
Date of Birth: _____/_____/_____	Date of Birth: _____/_____/_____
Address: _____	Address: _____
SS#:_____-_____-_____	SS#:_____-_____-_____
Insured's Employer: _____	Insured's Employer: _____
Relationship to patient: _____	Relationship to patient: _____

ASSIGNMENT OF BENEFITS AND RELEASE

I certify that I, and/or my dependent(s) have insurance coverage with the insurance company(s) listed above and assign directly to Advanced Psychiatry, PLLC, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the use of my signature on all insurance submissions.

Advanced Psychiatry, PLLC may use my healthcare information and may disclose such information to the above-named insurance company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will be in effect for one year from the date signed below.

I HAVE READ AND FULLY UNDERSTAND THE AGREEMENT.

_____ _____

Patient signature (Parent /Guardian's signature if patient is under 18) Date

_____ _____

Patient Name (please print) Relationship to patient

Advanced Psychiatry Office and Financial Policies

Appointments:

Our office is open Monday-Thursday from 7:00am- 5:00pm and Fridays from 7am- 12:00pm. Please call the office to make an appointment. If you are unable to keep your appointment, please call us as far in advance as possible so we may use that time to see another patient in need of care. ***If you do not cancel your appointment 24 hours in advance or do not show up for your scheduled appointment, our policy is to charge the rate of ($50.00) and is payable prior to future visits.*** These will not be billed to your insurance company.

If you are running late and miss more than half of your allotted appointment time, you may be asked to reschedule. Our appointments are scheduled with enough time to provide safe, quality care. If you would like to wait for a same-day appointment, you will be notified of the next available appointment time, otherwise you may not be seen until the end of the day.

Refill Requests / Messages:

Medication refills are only addressed during office hours. All requests for prescription refills must be made 48 business hours in advance to allow for processing time. In the event that you call our office and your clinician is out, your call will be returned the next business day.

Emergency Situations / After Office Hours:

For urgent matters after business hours, please call our main phone number for the provider on call. Please note that there will be a $25 fee for all after-hour urgent calls. In an emergency, call 911 or go directly to the nearest emergency room.

Insurance:

Our providers are currently in network with United Healthcare, Blue Cross Blue Shield, Aetna, Cigna, Humana, Magellan, Multiplan/PHCS,UMR and Tricare.

We are not accepting Medicare or Medicaid.

Financial Policy:

Patients are responsible for their co-payments and/or deductibles at the time services are rendered. The fees that charge for services are usual and customary for this area. Your insurance policy may base its allowance on a fixed fee schedule, which may or may not coincide with our fees. You should be aware that different insurance policies could vary greatly on the types of coverage available. You will need to check with your insurance company regarding the specific coverage you may have.

If you have secondary insurance, you agree to provide us with this information at the time of scheduling, so we can get accurate benefit information and file the appropriate claim form for you.

We do not accept Medicare or Medicaid patients. If you are a Medicare or Medicaid patient or anticipate applying for Medicare or Medicaid for the payment of the services rendered to you, by signing this agreement you understand that our clinician is accepting you as a private pay patient and not as a Medicare or Medicaid patient for any services rendered to you and that you will be responsible for paying for the services you received from our clinician. We will not file a claim to Medicare or Medicaid for services provided to you.

Fee Disclosure Acknowledgement:

Most fees are for office procedures. However, fees will also be incurred when you request services in addition to your regular services. **These fees may not be payable by your insurance plan and are to be paid at the time services are rendered.**

The following is a brief, non-comprehensive listing of such services:

1.	Medical records	$25.00 and up
2.	Returned checks (NSF)	$30.00
3.	Letters to employer, school, etc.	$25.00 and up
4.	Disability forms, letters, etc	$25.00 and up
5.	Missed scheduled appointment	$50.00
6.	Canceled scheduled appointment with less than 24 hour notification	$50.00
7.	Non-emergent after hour calls	$25.00
8.	Medically necessitated and clinically indicated telephone appointment	$125.00

Our office will not fill out any paperwork, forms or write any letters regarding CHL (concealed handgun license) clearance or emotional support animals.

I have read and understand the Office Policy, and I agree to accept responsibility as described above. I also understand the Office Policy may be amended or modified from time to time by the practice. I am expressing my understanding by signing below.

_____ _____

Patient Name (please print) Date

_____ _____

Signature of Patient/Parent/Guardian/Representative Relationship to patient

NOTICE OF PRIVACY POLICIES AND PRACTICES

Advanced Psychiatry
1100 E Southlake Blvd Suite 300, Southlake TX, 76092
Office: 817-873-0590 Fax: 817-873-0591

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

All items outlined in this policy apply to both paper and electronic formats of medical records and protected health information.

INTRODUCTION

Advanced Psychiatry is committed to treating and using protected health information about you responsibly. We are permitted to use and disclose health information about you for treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. This notice describes our privacy practices. We may change our policies and this notice at any time. You can request a paper copy of this notice, or any revised notice, at any time. This Notice applies to all protected health information as defined by federal regulations. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted to use and disclose your health information to those involved in your treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We are permitted to use and disclose your health information to bill and collect payment for the services we provided to you. Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order to pay for the service rendered to you.

We are permitted to use and disclose your health information for the purpose of health care operations, which are the activities that support this practice and ensure that quality care is delivered. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

These are situations in which we are permitted to use or disclose your health information without your written authorization or an opportunity to object.

Public Health: We may disclose your health information for public health activities mandated by federal, state or local government for the collection of information about disease, vital statistics or injury by a public health authority.

Abuse or Neglect: Because Texas law requires physicians to report child abuse or neglect, we may disclose health information to a public agency authorized to receive reports of child abuse or neglect.

Healthcare Oversight: We may disclose your health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections.

Law Enforcement and Legal Proceedings: We may disclose your medical information if asked by a law enforcement official. We may also release information if we believe the disclosure is necessary to prevent or lessen imminent threat to the health or safety of a person. We may disclose your health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

Worker's Compensation: We may disclose your health information as required by worker's compensation law.

Military and National Security: We may disclose your health information for specialized governmental functions.

Research and Medical Examiners: We may release health information to researchers for research purposes. We may release your health information to a coroner or medical examiner to identify a deceased person or a cause of death.

Business Associates: We may disclose your health information to "business associates" to perform our day-to-day operations. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Appointment Reminders: We may contact you by telephone, mail or both to provide appointment reminders.

Required by Law: We may release your health information when the disclosure is required by law.

Other Uses or Disclosures*:* Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

YOUR RIGHTS UNDER FEDERAL LAW

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information, WE DO NOT HAVE TO AGREE TO THIS RESTRICTION.
- The right to limit disclosure to family members, relatives or friends who may or may not be involved in your care. Restrictions must be submitted in writing.
- The right to request that we send communications concerning health information by alternative means or to an alternative location. The request must be submitted in writing and we are required to accommodate only reasonable requests.
- The right to inspect and copy your protected health information that is within the designated record set. Texas law requires that request for copies are made in writing and we require requests for inspection also be made in writing. Texas law requires us to provide copes or a narrative within 15 business days from receipt of your proper request. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.
- The right to amend or submit corrections to your protected health information in the designated record set. If we refuse to allow amendment, we will inform you in writing.
- The right to receive an accounting of disclosures that are other than for treatment, payment, health care operations or made via an authorization signed by either you or your representative.
- The right to receive a printed copy of this notice.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C., 20201

OUR RESPONSIBILITIES

Advanced Psychiatry is required by law and regulation to protect the privacy of your health information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

If you have complaints, questions, or would like additional information regarding this notice or the privacy practices of Advanced Psychiatry, please contact our Privacy Official:

Advanced Psychiatry
1100 E Southlake Blvd, Suite 300
Southlake, TX 76092
(817) 873-0590

REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

I have reviewed Advanced Psychiatry's Notice of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____	_____
Name of Patient or Personal Representative	Date
_____	_____
Signature of Patient or Personal Representative	Description Personal Representative's Authority

Optional:

_____	_____
Additional Authorized Patient Personal Representative	Relationship
_____	_____
Additional Authorized Patient Personal Representative	Relationship
_____	_____
Additional Authorized Patient Personal Representative	Relationship